Howard-Suamico School District

Authorization to Administer

PRESCRIPTION MEDICATION

(Use a separate authorization form for each medication)

Student: _____ DOB: _____

School: _____ Grade: _____

FOR COMPLETION BY PHYSICIAN

Reason for medication: _____

Name of Medication: _____

Dosage: _____

Start date of medication: _____ Stop date of medication: _____

Administration: ☐ Daily/Scheduled. Time: _____

☐ As needed: Indication for use: _____

If needed, how soon can administration of medication be repeated? _____

Medication cannot be repeated more then: _____

Side effects when contact should be made with you: _____

_____

Physician's Name: _____

Telephone Number: _____ Fax Number: _____

I am a licensed healthcare professional authorized to prescribe drugs and have prescribed the above medication to named student.

NOTE: Your signature attests to your willingness and intent to direct, supervise, decide, inspect and oversee the administration of the medication by the non-medically trained designees and that you will accept direct communication from them regarding the administration of the medication. We urge that all instruction be stated in language of the lay person.

_____ _____

Physician Signature: Date:

Fax completed signed form to 920-662-7900 – Pupil Services

FOR COMPLETION BY PARENT/GUARDIAN FOR PRESCRIPTION MEDICATIONS

A. Parent must deliver the medication to school in its original or prescription container.
B. Parent will notify the school immediately if there is any change in the use of the medication or the prescribed treatment.
C. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

Phone #1: _____ Phone #2: _____

Parent/Guardian Name (print) _____

_____ _____

Parent/Guardian Signature: Date:

Parent: Return completed signed form to school office.