Kansasville School District

Authorization for Administration of Prescription Medication

Student's Name__________________________________D.O.B_____________Grade_______

FOR COMPLETION BY PHYSICIAN

DAILY MEDS

Medication	Dosage	How it is to be given	Time to administer	Duration (all school year or specify)	Reason for Medication

AS NEEDED MEDS

Medication	Dosage	How it is to be given	Time to administer	Duration (all school year or specify)	Reason for Medication

The above medication(s) are to be administered during the school day in accordance with above instructions. I agree to accept communication about the student and/or medication and understand that non-medical, trained school personnel may administer the medication(s).

Asthma Inhalers and EpiPens only: It is my professional opinion that the student named above **__MAY __MAY NOT** carry and self-administer the above prescribed **___ INHALER and/or____ EpiPen.** He/she has been instructed in and understands the purpose and appropriate use of the medication.

Physician's Name:	Clinic Phone:	Fax:
Physician's Signature:	Date:	

FOR COMPLETION BY PARENT/GUARDIAN

As the parent/guardian of the above-named student, I have read and understand the school's medication policy and give the Kansasville School District permission to administer the medication authorized by my physician. I will notify the school district immediately of any changes in medication profile or health concerns of my child. I authorize the District Nurse to contact the medical provider for clarification of this medical order or to report any adverse reactions or side effects.

***Asthma Inhalers and EpiPens only:** I herby request that my child carry and self-administer the above inhaler/EpiPen. I have discussed this with my child and deem this responsibility appropriate for him/her.

Parent/Guardian Signature:	Phone:	Date:

Reviewed by the School Nurse:____Date:________________________