AUTHORIZATION FOR ADMINISTRATION OF PRESCRIPTION MEDICATION

☐ Leona Doubek Elementary	☐ Prairie View Elementary	☐ East Troy Middle School	☐ East Troy High School
Phone: 262-642-6730	Phone: 262-642-6720	Phone: 262-642-6740	Phone: 262-642-6760
Fax: 262-642-6723	Fax: 262-642-6788	Fax: 262-642-6743	Fax: 262-642-6776

Last Name:_____ First Name:_____ Date of Birth:_____ ☐M ☐F

Parent's Name:_____ Home #:_____ Cell #:_____

Physician's Name:_____ Phone #:_____ Fax #:_____

Physician's Address:_____ City:_____ St:_____ Zip:_____

TO BE COMPLETED BY THE PHYSICIAN

According to the State of Wisconsin Medical Examining Board and the East Troy School District's "School Medication Policy", it is required to complete this form before school personnel may dispense or administer medication.

Medication Name:_____ Dose:_____ Frequency:_____

Route: ☐Oral ☐Inhalation ☐Eye/Ear/Nose Drops ☐Topical ☐Other: _____

Time of day to be given:_____ ☐AM ☐PM Recommended Duration:_____

If PRN, describe indication(s):_____ If PRN, how often can it be repeated:_____

Side Effects (expected or predictable):_____

Adverse Effects (require notification of parent/physician):_____

Special Instructions:_____

Self-Administration of Medication by Student: It is strongly recommended that all medication be administered by designated school staff and be kept secure in the school office. No controlled substances may be kept or self-administered by the student. Students (grade 6-12) may self-administer medication provided parent and physician authorization is granted.

☐**This student may carry and self-administer this medication.**

I am willing to accept direct communication from the person dispensing or administering the medication.

Physician's Signature:_____ Date:_____

If phone order, taken by:_____ Date:_____

Phone orders expire in 10 days, if not signed by a physician.

TO BE COMPLETED BY THE PARENT/GUARDIAN

I request and authorize that my son/daughter be assisted in taking the medication described above at school by designated school staff. I hereby release the Board of Education and its agents and employees from any and all liability that may result from my child taking the prescribed medication. I consent to any communication between the prescribing physician (or health care practitioner) and the school regarding this medication and related health information.

☐**If applicable, I agree with the physician's statement above regarding self-administration.**

Parent/Guardian's Signature:_____ Date:_____