Expect Excellence
School District of New Berlin

Authorization to Administer Prescription Medication

Student _____ **Birth date** _____

School _____ **Grade** _____ **School Year** _____

Parent/Guardian 1: _____ **Parent/Guardian 2:** _____

Daytime Phone (_____) _____ **Daytime Phone (_____)** _____

Cell (_____) _____ **Cell (_____)** _____

Authorization expires at the end of the school year or following the summer school session.

Parent/Guardian Medication Consent:

I give permission for my son/daughter to receive the medication listed below from a school staff member appointed by the school principal. Students are not permitted to self-administer or carry medication, except asthma inhalers, insulin or an epi-pen as prescribed by their physician. I agree to hold the New Berlin School District harmless in any and all claims arising from the benefits or consequences of this medication which the physician has prescribed and my child has taken. I understand that, if my child refuses the prescription medication, force will not be exerted by school personnel to facilitate compliance. I understand that the school is not responsible for the loss of medication due to the carelessness on the part of the child. I authorize the prescribing physician of this medication to disclose by any means (including written, oral, or electronic means) the information necessary to administer this medication to School District of New Berlin employee administering the medication.

I understand that it is my responsibility to:

- **Transport the medication to school in the original *pharmacy-labeled* container. The label shall include the name and telephone number of the pharmacy, the name of the student, the name of the prescribing physician, the name of the medication, the medication's storage requirements and the dosage to be given.**
- Replace the supply of medication when needed. Expired medication will not be administered to students.
- Pick up medication or direct staff to discard remaining medciation upon discontinuation or at the end of the school year.

Parent/Guardian Signature _____ Date _____

Health Care Provider's Order for Medication to Be Given at School

Medical Condition:		
Name of Medication: (generic and trade)		
Dosage of Medication:	_____mg / cc / tsp _____drops / puffs	Form: ☐ Tablet / Capsule ☐ Liquid ☐ Inhaler ☐ Nebulizer ☐ Other _____
Route:	☐ Oral ☐ Eyes ☐ Ear ☐ Nose ☐ Topical ☐ Rectal ☐ Other _____	
Administration Time:	☐ **Daily at:** _____ ☐ **As needed**- Describe frequency & symptoms for which medication should be given: ☐ May be repeated in _____ (time) minutes/hours.	
Possible Side Effects:		
For inhaled asthma, insulin and eipi-pen medication ONLY:	☐ In my professional opinion, this student should be allowed to carry and use this medication by him/herself. Qty given to office to hold_____Qty on student_____ ☐ In my professional opinion, this student ***SHOULD NOT*** carry this medication by him/herself.	

Health Care Provider's Name (Please print) _____ Phone (____) _____

Health Care Provider's Signature _____ Date _____