

Mukwonago Area School District

Authorization to Administer *Prescription* Medication

Student _____ Birth Date _____
 School _____ Grade _____ School Year _____
 Parent/Guardian _____ Daytime Phone (____) _____ Cell (____) _____
 Health Care Provider Name _____ Phone (____) _____
 Health Care Provider Address _____

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 by designated school personnel. I understand that MASD and the school personnel administering the medication below is not liable for any adverse reaction suffered as a result of administration. My child has taken the medication below previously and has not experienced an adverse reaction. I also give permission for an exchange of information between school district personnel and the health care provider, if necessary, regarding this medication. I agree to notify the school in writing for the withdrawal of this request or when a change in this medication occurs.

I understand that it is my responsibility to:

- Transport the medication to school in the **original** *pharmacy-labeled* container; and the container specifies the students name, name of prescriber, the name of medication, the dose, the effective date, and the directions for administration.
- Replace the supply of medication when needed.
- Pick up medication 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:	
Form of Medication:	<input type="checkbox"/> Tablet / Capsule <input type="checkbox"/> Inhaler <i>(For Inhaler: See Asthma Care Plan)</i> <input type="checkbox"/> Liquid Drops <input type="checkbox"/> Spray <input type="checkbox"/> Other _____
Medication Strength: (How many MG per Tablet / ML / tsp)	
Dose of Medication: (How much should we give)	_____ mg _____ ml / cc _____ tsp Other _____
Administration Time:	<input type="checkbox"/> Daily at: _____ <input type="checkbox"/> As needed (Describe frequency & symptoms for which medication should be given) _____ <input type="checkbox"/> May be repeated in _____ minutes / hours (Time)
Possible Side Effects:	
Self-Carry / Self-Administer: Grades (7 - 12) <i>Only inhaler, Epinephrine, and over the counter prescription strength medication may be carried.</i>	<input type="checkbox"/> In my professional opinion, this student should be allowed to carry and use this medication by him/herself. <input type="checkbox"/> In my professional opinion, this student <i>SHOULD NOT</i> carry this medication my him/herself.

I accept direct communication from school personnel administering this medication at school or school sponsored event.

* **Health Care Provider's Signature** _____ **Date** _____

Fax Numbers:

Big Bend 262-662-1309

Clarendon 262-363-6289

Eagleville 262-594-5495

Prairie View 262-392-6312

Rolling Hills 262-363-6343

Section 262-363-6341

Park View 262-363-6320

Mukwonago High 262-363-6239

District Nurse Phone: 262-363-6292 x27515 Fax: 262-363-6320

Entered in Infinite Campus By: _____ Date: _____

06/2013 by LAH