Parental Permission to Administer PRESCRIPTION MEDICATION
Boyceville Community School District

 # 1 Student Information/ Medication Instructions:

School Year or Effective Date _____ School _____ Grade _____

Student's Name _____ Birthdate _____

Medication _____ Dosage _____ Time _____Route _____

Reason for Medication _____

***Note requirements: *Signed* **Physician Order (2)** and *signed* **Parent Consent (3)**

 # 2 Physician Order: Complete for **Each Prescription Medication** at school:

This medication is to be administered during the school day in accordance with the instructions listed in # 1. Please contact me if the following symptoms occur:

_____

_____

Asthma Inhalers Only: Student may carry inhaler in school. Yes/ No

Date _____ physician's Signature _____

Clinic Name/ Address _____ Phone _____

 # 3 Parent Consent: Complete for **Each Medication** at school:

I request that this medication be administered at school by designated employee(s) and release said employee(s) from liability.

I will supply the medication in its original, properly labeled pharmacy container.

I will count the medication and will notify the school of the amount being sent.

I will/ or have a designated adult bring the medication to school.

I will notify the school **in writing** of any medication changes and will obtain a new physician's order.

I authorize school personnel to contact my child's physician if needed.

This consent is in effect for the school year unless otherwise indicated.

Date _____ Parent/ Guardian Signature _____

Phone (home) _____ (work) _____ (cell) _____