Elementary fax 715-289-3017 Jr./Sr. High School fax 715-289-3085

# School District of Cadott Community

## Authorization for Administration of Medication: Prescription Medication

Name of Student:______________________________ Date of Birth:__________

Parent/Guardian:______________________________ Phone:__________

Address:______________________________ Grade:__________

Student's Condition/Diagnosis:______________________________

**Part 1: Physician's Statement:**

1. Name/type of medication:______________________________
2. Route:______________________________
3. Dosage/amount to be given:______________________________
4. Frequency/times to be administered:______________________________
5. Duration (week, month, indefinite, ect.):______________________________
6. Possible reaction to medication (side effects, symptoms, etc.):______________________________
   ______________________________
7. Known Allergies:______________________________
8. Contact MD should the following occur:______________________________

☐ Please check if student has been instructed in the proper way to use inhaled asthma medication and it is in your professional option that he/she should be allowed to self-carry and self-administer this inhaled medication as prescribed if needed prior to exercise or to alleviate asthma symptoms.

______________________________ __________

(Physician's signature) (Date Signed)

Physician Name:______________________________ Phone:__________ Fax:__________

**Part 2: Parent/Guardian Request/Approval:**

I hereby request and give my permission for the above named school to administer the medication prescribed on this form to my child, and I authorize them to contact the student's physician, if necessary. I further exonerate the Cadott School District from any liability resulting therefrom. I shall inform the school of any change in the student's health or medication.

______________________________ __________

(Parent/Guardian's signature) (Date Signed)

Prescription medication must be accompanied by written physician authorization and also parent/guardian written consent. Prescription medication must be in the original prescription container with the label affixed. Student, doctor, name of drug, dosage and frequency must be indicated. If prescription or dosage changes, a new physician's authorization is required and new prescription information must be on the container.