# FOND DU LAC SCHOOL DISTRICT – SCHOOL HEALTH PROGRAMS

72 W. Ninth Street, Fond du Lac, WI 54935 Telephone 920-906-6548 FAX 920-906-6563

## MEDICATION AUTHORIZATION

Student's Name: _____ D.O.B: _____ School: _____ Grade: _____
Prescribing Physician: _____ Physician Address: _____
Physician Phone: _____ Physician Fax: _____
Diagnosis 1: _____ 2. _____

**Parent Permission**

I am requesting that my child receive prescription or over-the-counter medication at the time indicated and as designated by his/her medical provider. I will be responsible for bringing the prescription drugs to school in a labeled container from the pharmacist. I also understand that I am responsible for maintaining a sufficient quantity of the medication or supplies at the school. Failure to do this will result in an interruption of the physician's order or discontinuation of the school's administration of the medication/procedure for my child. I understand that, if my child refuses to take the medication(s), force will not be used by school personnel to make my child comply. School personnel have permission to communicate with the prescribing medical provider regarding use, side effects, response, and contraindications of the medication(s) or the procedure results of frequency. I can rescind my permission at any time.

| _____ | _____ | _____ |
|---|---|---|
| Parent/Guardian Name/Relationship | Address | Phone Number |
| _____ | _____ | _____ |
| Signature of Parent/Legal Guardian | Date | Email |

**Health Care Provider Authorization:**

I am prescribing the following medication and procedures for the above student to be administered or performed at school.

**DAILY**

| Name of Daily Medication (Generic and Trade Name) | Dosage/ Frequ-ency | Time(s) (AM/PM): | Start date | Stop date | Allowed to Self-Admin (Grades 9-12 only) | Not Allowed to Self-Admin (Grades 9-12 only) | Possible Adverse Side Effect or Contraindications: |
|---|---|---|---|---|---|---|---|
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**PRN (AS NEEDED)**

| Name of PRN Medication (Generic and Trade Name) | Dosage/ Frequ-ency | Time(s) (AM/PM): | Start date | Stop date | Allowed to Self-Admin (Grades 9-12 only) | Not Allowed to Self-Admin (Grades 9-12 only) | Indicate conditions for which it is used for and possible adverse side effects or contraindications: |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
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**INHALERS/INSULIN/EPI-PEN:**

_____ Inhaler/Insulin/Epi-Pen (circle one) is kept by designated school personnel and used under supervision
_____ Inhaler; totally independent (Has been trained by physician on use and is prepared to self-administer-grades 6-12 only)
_____ Insulin; totally independent (Has been trained by physician on use and is prepared to self-administer-grades 6-12 only)
_____ Epi-Pen; totally independent (Has been trained by physician on use and is prepared to self-administer-grades 6-12 only)

**PLEASE NOTE: The above orders shall be effective throughout the current school year and summer school unless the orders are discontinued, changed or withdrawn in writing by the parent/guardian before that time elapses.**

| _____ | _____ |
|---|---|
| Physician's Signature | Date (Mo/Day/Yr) |