Authorization to Administer PRESCRIPTION Medication by School Personnel
School District of Thorp

_______________________________ _______________
Name of Student Date of birth

_______________________________ _______________
Homeroom Teacher Grade

Parent Consent

I hereby give my permission to the principal/designee to give the medication or perform the procedure to my child according to the written instructions of the doctor as shown below. I also hereby agree to give my permission to the school nurse to contact my child's physician.

I agree to notify the school at the termination of this request or when any change in the below order is necessary.

__________ ____________________________ ______________ ______________
Date Parent/Guardian Signature Home phone Work phone

Physician complete this section:

This is to certify that ________________________________(student) identified above is being attended and treated by me. It is essential that he/she be given the following medication in the dose indicated during school hours.

Name of physician prescribing medication ________________________ ________________
Print physician name here Phone number

Name of medication____________________________ Reason for medication ______________

Dosage and route____

Hour(s) to be given in school____

Possible side effects____

Length of time to be given____

_______________________________ _______________
Signature of physician Date

Note: It is the parent's responsibility to see that the school personnel receive this authorization. No medication will be given at school without signed consent of parent.

Authorization for Administration of INHALED Medication
School District of Thorp

Name of Student ______________________ Date of Birth ______________

Homeroom Teacher ______________________ Grade ______________

For Completion by Physician:

Print Physician's Name ____________________________________
Telephone Number: ________________ Fax Number: ____________
Diagnosis: ____________________________________
Name of Medication: ____________________________________
Form of Medication: ____________________ Dose: ____________
Is the child knowledgeable about his/her asthma medication? Yes________ No________
Has the child demonstrated the proper technique in administering the medication? Yes______ No______
Is the medication administered daily? Yes______ No______ Time: ____________
Medication is administered when needed. Indications: ____________________
If needed, how soon can administration of medication be repeated? ____________
The medication cannot be repeated more than ____________________
Side effects: ____________________________________
Comments: ____________________________________

( ) I have instructed ______________________ in the proper way to use his/her inhaled asthma medications. It is my professional opinion that he/she should be allowed to carry and use this inhaled medication by him/herself.

( ) It is my professional opinion that ______________________ should not carry and use his/her inhaled asthma medication by him/herself.

Signature of physician ______________________ Date ______________

For Completion by Parent:

Print Parents name ____________ Home phone ____________ Work phone ____________ Emergency phone ____________

Is the child authorized to carry and self-administer inhaled asthma medication? Yes________ No________

As the parent of the above named student, I ask that assistance be provided to my child in taking the medication(s) indicated above at school by authorized personnel. If self-medicating is allowed or if no authorized staff member is available, I ask that my child be permitted to self-medicate as authorized by myself and my child's physician.
Authorization is hereby granted to release this information to appropriate school personnel and classroom teachers.

Parent/Guardian signature ______________________ Date ______________

Authorization to Administer NON-PRESCRIPTION Medication by School Personnel
School District of Thorp

Name of Student		Date of Birth
Homeroom Teacher		Grade
Name of Medication	Dosage	Time/Frequency

Parent Consent

I understand the school will only administer necessary medications during the school day.

I understand the school will not administer medication that is expired or at a dosage that is outside the recommended amount listed on the container.

I will supply the medication in its original labeled container.

I request that this medication be administered at school by designated personnel.

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

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

Parent/Guardian Signature	Date	Home number	Work number

Note: It is the parent's responsibility to see that the school personnel receive this authorization. No medication will be given at school without signed consent of the parent.