SCHOOL DISTRICT OF BAYFIELD PRESCRIPTION MEDICATION
PHYSICIAN AND PARENT (GUARDIAN) AUTHORIZATION FORM

STUDENT NAME _____ DOB _____

To be completed by physician / licensed practitioner/traditional practioner :

	Medication Name	Dose	Time to be given	Form/Route	Side Effects	Adverse Reactions
1.						
2.						

Medication given at school must be in the correct pharmacy container labeled with the student's name, pharmacy name and # , physician name, and medication name, dosage, and frequency to be given.

Reason for medication (optional) Medication #1: _____ Medication #2: _____

Special instructions: _____

Start date if not beginning of the school year: _____ **Stop date** if not the end of the school year _____

List minimal frequency between doses (especially if PRN): _____
If PRN, list symptoms/conditions for which medication is to be given:_____

Physician's/Practitioner's Signature: _____ Date: _____

Printed Name _____

Physician's Phone # : _____ Fax # _____ Address _____

_____

To be completed by parent / guardian:

I request and give permission for **(Student's Name)__** _____ **Grade**: _____ to receive the above medication(s)/treatment at school according to standard school district policy and for the physician/staff and school district staff to share information needed to assist my child with medication needs. I agree to hold the School District of Bayfield, its employees and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication at school. I agree to notify the school in writing at the termination of this request or when any change is necessary.

Parent/Guardian Signature _____ Date _____

School Nurse Phone # 779-3201 Ext. 143 Fax # 779-5268

APPROVED: September 11, 2008