COLFAX SCHOOL DISTRICT

Parental Permission to Administer PRESCRIPTION MEDICATION

#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).

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.

I will pick up medication at the end of the school year.

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

Date: _____ Parent/Guardian Signature: _____

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

Colfax School District Phone (715) 962-3155; Fax (715) 962-4024