INDIAN COMMUNITY SCHOOL OF MILWAUKEE

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION: **2016-2017**

REQUIRED for ALL Medications (Prescription and/or Over-The-Counter)

STUDENT:_____ Date of Birth:_____ Grade:_____

PHYSICIAN/PRESCRIBER AUTHORIZATION—REQUIRED FOR ALL MEDICATIONS

I authorize the at-school administration of the following medication to the student named above. I agree to be contacted by the School Health Office Personnel as needed regarding this medication.

_____	_____	_____
Name of Medication	Dose	Time(s) to give

Administer for: ☐ Full School Year (or) ☐ From _____ To _____

Reason Medication is given at school:_____

Side Effects or Contraindication:_____

If PRN, indications for use:_____

If PRN, actions after administration:_____

(IF)---SELF-AMINISTRATION OF ASTHMA RESCUE INHALER is requested on this form:

☐ The student is knowledgeable about their asthma rescue inhaler and its proper use. It is my professional opinion that the above named student should be allowed to carry and self-administer this medication by him/herself.

☐ It is my professional opinion that the above named student should **not** carry and self-administer the asthma rescue inhaler him/herself.

MUST BE SIGNED BY PHYSICIAN/PRESCRIBER BELOW:

_____	_____	_____
Date	**PHYSICIAN/PRESCRIBER Signature**	**Print Prescriber Name or Stamp**

Parent/Guardian/Legal Custodian Authorization-- REQUIRED

I, the parent/guardian/legal custodian of the above named student request the medication listed above be given at school. I will notify the school in writing if there is a change or cancellation of the medication. I will deliver a sufficient supply of the medication in a properly labeled container to the School Health Office. I give School Health Office Personnel my permission to contact the prescriber about this medication. I authorize release of information about my child's use of this medication to appropriate school personnel and classroom teachers.

I, the parent/guardian/legal custodian of the above named student, give my permission for the student to carry and self administer the asthma rescue inhaler requested on this form. ☐ Yes ☐ No

Signature of Parent/Guardian/Legal Custodian:_____ Date:_____