Authorization to Administer Medication
Barneveld School District

School Phone: 608-924-4711
Fax: 608-924-1646

Student Name:	Date of Birth:
Parent Name:	Daytime Phone:
Grade:	Teacher:

I/We: •give consent for school personnel to administer the following medications according to the directions stated by the above named licensed prescriber/physician. •consent to the free exchange of information regarding this medication between the licensed prescriber/physician and school personnel. •agree to notify the school in writing of any changes or termination of this request. •understand that the medication must be delivered to the school in the original over-the-counter or prescription package detailing instructions for medication administration including student name, drug dosage, time/frequency to be administered and physician name. •understand that any unused medication must be picked up at school by me/us by the last day of school or will be disposed of by school personnel. •agree to hold school personnel harmless in any and all claims arising from the administration of this medication at school or school related events. •understand that this medication order is in effect for the current school year only.

Parent/Guardian Signature:	Date:

DAILY MEDICATIONS					Diagnosis/Reason for Medication:
Medicine Name	Route	Dose	Frequency/Time	Duration	
				Start: Stop:	
				Start: Stop:	
				Start: Stop:	

PRN (as needed) MEDICATIONS					Condition under which medication should be given:
Medicine Name	Route	Dose	Frequency /Time	Duration	
				Start: Stop:	
				Start: Stop:	
				Start: Stop:	

According to school policy, no prescription medication will be administered to a student without written medication orders from parent and physician. These orders must include the name of the drug, dosage, frequency/time to be administered, length of time medication is to be administered, reason medication is prescribed and conditions under which contact with the physician should be made.
I am prescribing medication for the above named student who has a diagnosis of:

Licensed Prescriber/Physician Signature:	Date:
Prescriber/Physician Name:	Phone:
Office/Clinic Address:	Fax:

APPROVAL FOR STUDENT CARRYING AN INHALER and/or EPI-PEN	
This student has received instruction and has demonstrated competency in the use of a: **Metered Dose Inhaler or Epi-Pen** (circle). He/She may carry and self-administer as prescribed: **YES NO** (circle).	
Licensed Prescriber/Physician Signature:	Date:
School Nurse/Administrator Signature:	Date:

END OF YEAR MEDICATION RETURN	
Indicate below your preference for medication return. Any medications left behind after June 30, 2023, will be disposed of.	
____Parent will pick up by May 31, 2024. ____Please send home with _____ by May 31, 2024 ____Please keep in office through summer school, then send home with:	
Parent Signature:	Date:

Revised: 011-14-2023