School District of New Berlin
Parent/Physician Authorization - Prescription Medication

Parental Consent

Student Name_____ School_____

I request and authorize that my child, _____receive medication from a school staff member appointed by the school principal.

I shall supply a properly labeled medication. The label shall include the name and telephone number of the pharmacy, the name of the student, the name of the prescribing physician, the name of the medication, the medication's storage requirements and the dosage to be given. I understand that the school is not responsible for the loss of medication due to the carelessness on the part of the student.

Expired medication will not be administered to students. It is the parents responsibility to replace the medication before it is expired.

Students are not permitted self-administer or carry medication, except asthma inhalers, insulin or an epi-pen as prescribed by their physician.

I agree to hold the New Berlin School District harmless in any and all claims arising from the benefits or consequences of this medication which the physician has prescribed and my child has taken. I understand that, if my child refuses the prescription medication, force will not be exerted by school personnel to facilitate compliance.

I agree to notify the school in writing at the termination of this request or when any change in the above orders is necessary.

I authorize the prescribing physician of this medication to disclose by any means (including written, oral, or electronic means) the information necessary to administer this medication to New Berlin Public School employee administering the medication.

_____ _____

Date Signature of Parent/Legal Guardian

Physician's Order for Prescription Medication

Date effective _____to _____

Student Name_____ Birthdate_____

Name of Medication_____ Purpose_____

Dosage_____ Route: _____

Frequency/Administration time _____

Possible side effects to be observed:_____

If PRN medication, to be given for what symptoms?_____

Self-Administration is only permitted for Epi-Pens, Insulin, and Asthma Inhalers. If authorization is for one of these medications, is it safe for this child to carry and self-administer this medication? Please circle answer: YES NO NOT APPLICABLE

I am willing to accept direct communication from the person dispensing or administering the medication.

_____ _____ _____

Signature of Prescribing Physician Telephone Number Date