Unity School District

Parental Permission to Administer PRESCRIPTION MEDICATION

#1 **Student Information / Medication Instructions:**

School Year or Effective Date: _____ School: _____ Grade: _____

Student 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) and release said employee(s) from liability.

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.

This consent is in effect for the school year unless otherwise indicated, and will notify the school in writing when the medication is discontinued.

Date _____ Parent/Guardian Signature _____

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

Fax: 715-825-4430 Phone: 715-825-2101