PORT WASHINGTON-SAUKVILLE SCHOOL DISTRICT

We educate all children to reach their greatest potential.

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MEDICATION/PROCEDURE AUTHORIZATION

_____ _____ _____ _____
Student's Name Date of Birth School Grade

Diagnosis:
1._____ 2. _____

Parent Permission: I am requesting my child, _____, receive prescription drugs or procedures at the time indicated and as designated by his/her medical provider.

I will be responsible for bringing the prescription drugs to school in a labeled container from the pharmacist. I also understand I am responsible for maintaining a sufficient quantity of the medication or supplies at the school. Failure to do this will result in an interruption of the physician's order or discontinuation of the school's administration of the medication/procedure for my child. I understand if my child refuses to take the prescribed medication(s) or allow the procedure(s), force will not be used by school personnel to make my child comply.

School personnel have permission to communicate with the prescribing medical provider regarding use, side effects, response, and contraindications of the medication(s) or the procedure results or frequency. I can rescind my permission at any time.

_____ _____ _____
Parent/Legal Guardian Signature Relationship Date

Health Care Provider Authorization:
I am prescribing the following medication and procedures for the above student to be administered or performed at school.

DAILY

Name of Daily Medication (Generic and Trade Name)	Dosage/ Frequency	Time(s) (AM/PM):	Start date	Stop date	Possible Adverse Side Effect or Contraindications:

PRN

Name of PRN Medication (Generic and Trade Name)	Dosage/ Frequency	Time(s) (AM/PM):	Start date	Stop date	Possible Adverse Side Effect or Contraindications:

PROCEDURES

Name of Procedure (CIC, glucose checks, suctioning, etc.):	Dosage/ Frequency	Time(s) (AM/PM):	Start date	Stop date	Monitoring Parameters

_____ _____ _____
Medical Provider's Signature Date Telephone/Fax Number

_____
Printed Medical Provider's Name