River Falls School District

PRESCRIPTION MEDICATION AUTHORIZATION FORM

1. A prescription medication may be administered to a student in compliance with the written instruction of a practitioner and written consent from the student's parent/guardian.
2. All prescription medications need to come to school in the original pharmacy-labeled package: and the package specifies the name of the student, the name of the prescriber, the name of the prescription drug, the dose, the effective date, and the directions in a legible format.
3. The Health Office staff cannot administer expired medication and medication that is not in its original pharmacy-labeled package.
4. The Health Office requires a written note from parent/guardian on discontinued medication.
5. The Prescription Medication Authorization Form needs to be renewed each school year and if medication orders change during the school year.

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Student Name_____ Birthdate_____

School _____ Grade _____

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To Be Completed by Practitioner

Medication _____

Dosage_____ Route of administration_____

Time of administration _____ Dates to be given _____

Reason for administration _____

Comments _____

Practitioner's signature_____ Date _____

Print name _____

Address_____Phone _____

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To Be Completed by Parent/Guardian

I request that the above mentioned medication be given as prescribed by the practitioner to my child. I will keep the school district aware of any changes in medication profile or health concern of my child. I give my medical provider and River Falls School District permission to release and obtain information from each other as necessary to administer medication. I understand that the medication will be disposed of if not picked up within one week following termination of the order, or one week beyond the close of school.

Parent/Guardian Signature _____ Date _____

"Practitioner" means any physician, dentist, optometrist, physician assistant, advanced nurse prescriber, or podiatrist licensed in any state.