## 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 <u>and</u> 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.

Student Name	Birthdate
School	Grade
*********	*************
<u>To l</u>	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
**********	***********
То Ве	Completed by Parent/Guardian
I request that the above mentioned me	dication be given as prescribed by the practitioner to my child. I
will keep the school district aware of an	y changes in medication profile or health concern of my child. I
give my medical provider and River Falls	s School District permission to release and obtain information
from each other as necessary to admini	ster 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.	RFSD (5/11) MK, PS