MINERAL POINT SCHOOLS

Student Name _____ Date of Birth _____

PRESCRIPTION MEDICATION PERMISSION AND INSTRUCTION FORM

To Be Completed by parent/legal guardian:

I am requesting that my child, _____, receive prescription drugs at the time indicated and as designated below by his/her physician/medical provider.

I will be responsible for bringing the prescription drugs to school in the **original labeled container** from the pharmacy. I also understand that I am responsible for maintaining a sufficient quantity of the medication at the school to avoid any interruptions in the prescriber's orders. Failure to do this will result in termination of the school's administered medication program for my child.

I understand that, if my child refuses to take the prescribed drug(s), force will not be used by school personnel to make my child comply.

_____ _____

(signature of parent/legal guardian) **Date (Mo./Day/Yr.)**

To Be Completed by physician/medical provider:

I am prescribing medication for _____ which is described as follows:

NAME OF MEDICATION (Generic & Trade Name)	DOSAGE & ROUTE	TIME	POSSIBLE ADVERSE SIDE EFFECTS	IF INHALER OR EPIPEN, STUDENT MAY SELF-CARRY & SELF-ADMINISTER
				YES or NO
				YES or NO
				YES or NO
				YES or NO

The above orders shall be effective through the end of the current school year unless they are discontinued, changed by me, or withdrawn in writing by parent/legal guardian.

_____ _____ _____

(Prescriber's PRINTED name) **(Prescriber's signature)** **(Date)**

_____ _____

(Clinic Name) **(Telephone #)**

Revised 3/14/23