Dent-Phelps R-3 School District
27870 Highway C
Salem, Mo. 65560

Phone: 573-729-4680 Fax: 573-729-8644

Authorization to Administer Prescribed Medication
Parental Consent

Name of Student:_____ Date of Birth: _____
School: _____ Grade: _____

Name of Parent/Guardian: _____
Phone: (home) _____ (work) _____

I give permission for my son/daughter to receive prescription medication during school hours.

I will be responsible for:

1. Delivery of medication in a pharmacy labeled container to the school office.
2. Maintaining a sufficient supply of medication.
3. Keeping school personnel informed of changes in the medication (dosage, time).
4. Obtaining a new form from the prescribing physician for any changes in this medication.

I hereby release the Board of Education and its agents and employees from any and all liability that may result from my child taking the prescribed medication.

_____ _____
(Parent/Guardian Signature) (Date)

Physician Order

I am prescribing medication for: _____ which is as follows:
(Patient's Name)

Name of Medication	Dosage	Form	Time	Possible Side Effects
_____	_____	_____	_____	_____

For metered dose Inhaler Only: This patient has received instruction and has demonstrated competency in the use of a metered dose inhaler. He/She may carry and self-Administer the inhaler as prescribed.

_____
Physician Signature

I understand the above information may be shared with necessary school personnel. The above order shall remain in effect through the end of the current school year unless discontinued or changed by me or the parent/guardian withdraws the request in writing.

Physician's Name: _____ Phone: _____

Physician's Signature: _____ Date: _____