HOWARD-WINNESHIEK COMMUNITY SCHOOL DISTRICT

Physician Order for Prescription Medication at School

Fax 1-563-547-2679

_____ _____ _____

Student Name Date of Birth School

_____ _____

Classroom Teacher Grade

_____ _____ _____

Medication Name Dosage Times to be given

_____ to _____

Start Date Stop Date

_____

Diagnosis / Reason Medication is given

How will medication be delivered to/from school:

☐Parent/Guardian ☐Student ☐Other_____

(If student rides a bus, the medication should be given to the bus driver to hold while on the bus)

I give my permission for my child to take medication at school, as ordered, and authorize school personnel to share pertinent information with school staff and contact my child's doctor, if necessary. I agree to provide the school with medication in its original, properly labeled container. I agree to notify the school in writing, when any changes in medication is necessary. I agree to release the school employees and school district, in which my child attends, from any and all liability claims arising from the administration of this medication at school.

_____ _____

Parent/Guardian Signature Date

I grant the school permission to administer this medication. Please contact me if the following symptoms occur: _____

_____

_____ _____ _____

Healthcare Provider's Name (Print) Healthcare Provider's Signature Date

_____ _____ _____

Provider's Telephone Number Address Fax Number

***Please request a second labeled container from the pharmacy for medications to be left at school.**