BES fax (715) 568-1045   BMS fax (715) 568-3687   BHS fax (715) 568-5304

Medication Authorization Form

Student	Birthday	Grade	Homeroom Teacher (BES)

Medication must be in its original container and not be beyond the expiration date. Over-the-Counter medications must be dispensed according to the label unless otherwise directed in writing by the Physician.

Over-the-Counter medications must be in containers of 50 or less pills.

Nutritional supplements/dietary supplements or other substances not regulated by the F.D.A. shall not be administered by School Personnel.

Prescription medication must be accompanied by written Authorization. Prescription medication must be in the original prescription container with label affixed. Label will include Student, Doctor, Name of Drug, Dosage, frequency and time (if needed). If prescription changes, a new physician's authorization is required and new prescription information must be on the container.

Name of Medication ______________________

Dosage (on bottle) ______________________

Dosage to be given ______________________

Time to be given ______________________

Frequency to be given ______________________

Reason to be given ______________________

Expected Side effects ______________________

Date to begin/end medication B______________

E______________

Allergies____________________________________

____

Possible Food/Medication Interaction

____

____

For inhaler please request alternate form from school that needs to by filled out.

Physician Name ________________________ Clinic & phone # ________________________

Signature ________________________ Date ______________

I hereby give my permission for school personnel to administer medication to my child. I agree to hold the Bloomer School District and its employees who may administer the medication harmless in any and all claims arising from the said administration of this medication at school.

Parent/Guardian Name ________________________ Phone # ____________________

Signature ________________________ Date ________________