

**MENOMINEE INDIAN SCHOOL DISTRICT**

453.4-Exhibit(1)

PRESCRIPTION MEDICATION AUTHORIZATION  
AND INSTRUCTION

CHECK PURPOSE OF AUTHORIZATION

\_\_\_\_\_ For the administration of prescription medication at school by staff  
\_\_\_\_\_ For self-carry/administration of medicine at school and after school activities

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PARENTAL AUTHORIZATION

Student's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_ Phone \_\_\_\_\_

Medication Name \_\_\_\_\_

Dosage \_\_\_\_\_ Time \_\_\_\_\_

\_\_\_\_\_ I request and authorize the school nurse and/or the designee to administer medication to my child in the appropriate dosage at the designated time. I dismiss the school district personnel from any liability that may result.

\_\_\_\_\_ I request that my child, named above, be permitted to carry and/or self-administer the above-ordered medication. I take responsibility for this permission. I understand that the medication must be in the original container and properly labeled.

\_\_\_\_\_ I authorize the school nurse and/or designee to order/pick-up my child's asthma medication that may be needed for school only.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

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PHYSICIAN'S INSTRUCTIONS

Diagnosis \_\_\_\_\_ Good for \_\_\_\_\_ School Year \_\_\_\_\_

Prescription and Instructions \_\_\_\_\_

Adverse Effects to report \_\_\_\_\_

Treatment of adverse effects \_\_\_\_\_

Check one below if for self-carry/administer medications:

\_\_\_\_\_ I have instructed the student named above in the proper way to use his/her inhaled asthma medications. It is my professional opinion that he/she be ALLOWED TO CARRY and use this medication him/herself at school.

\_\_\_\_\_ It is my professional opinion that the student named above SHOULD NOT CARRY and use his/her inhaled asthma medication by him/herself.

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

EXHIBIT APPROVED: May 2000, revised June 2010

REVISED: January 9, 2006