**United Community Center**
**Bruce Guadalupe Community Schools**

**Health Center Fax: 414-389-5118**
**School Nurse Phone: 414-649-2825**

# Prescription Medication Authorization

If your child requires ANY prescription medication at school and before ANY medication will be administered by school personnel this form must be completed. Parent/Guardian to complete top box and sign at bottom. The black bold areas must be completed and signed by the health care provider and brought into or faxed to the Health Center.

Student Name: ______________________________ Parent/Guardian: ____________________________

Birthdate: _________________ Age: _______ Preferred Language: _________________________

Grade/Class: ________ Phone Number: ______________________________

## Provider Order for Prescription Medication (s)

| Name of Medication | Dosage | Time/ Frequency | Potential Side Effects |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**REASON** for medication/diagnosis:

_____________________________________________________________________________

* Include **Asthma Action Plan** with asthma medication orders, as well as, any additional instructions if needed.

## Provider Approval for Student to Carry Emergency Medication

**Provider approval for self-carry/self-administration of medication: _____Yes _____ No**

Please circle medication for self-carry/self-administration: Metered Dose Inhaler, EPI Pen, Diazepam or other, list here: ____________________________________.

## Provider Signature for Order

→_________________________________________________________ **Date:** ____/____/______

Signature of Prescribing Healthcare Professional

**Prescriber's Printed Name:** ______________________________________________________

**Clinic Name/Address**: __________________________________________________________

**Phone:** (______) ________-__________ **Fax:** (______) ________-_________

Parent/Guardian: read & sign below. I give permission for school personnel to administer of the above listed medication(s) as authorized by my health care provider. I agree to notify Health Center directly at the termination of this request or when any changes to the above order is required. I authorize the school nurse to contact the physician directly for clarification of this medical order or to report any adverse reactions / side effects. I understand that it may be necessary to share the information on this form with other school staff to ensure proper administration of this medication. This information may also be shared with emergency medical staff in the event of an emergency requiring transport to a medical facility. At end of the each school year, I understand I must pick up unused medications from the Health Center or they will be properly disposed of at the end of the school year.

_____________________________________________________________ _______/______/________

Signature of Parent/Guardian Date

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# Prescription Medication Authorization

Si su hijo requiere CUALQUIER medicamento prescrito en la escuela y antes que el personal de la escuela administre CUALQUIER medicamento, debe completar este formulario. Padre/Guardián complete la primera cajilla y firme en la parte inferior. Las áreas en negro deben ser completadas y firmadas por el proveedor de salud y debe ser entregado al Centro de Salud para Estudiantes en persona o enviado por fax.

Nombre del Estudiante: ________________________ Padre/Guardián: _________________________

Fecha de Nacimiento: ____________ Edad: ______ Idioma preferido: _________________________

Grado/Clase: ________ Número de Teléfono: ______________________

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## Provider Order for Prescription Medication (s)

| Name of Medication | Dosage | Time/ Frequency | Potential Side Effects |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**REASON** for medication/diagnosis:

______________________________________________________________________________

* Include **Asthma Action Plan** with asthma medication orders, as well as, any additional instructions if needed.

## Provider Approval for Student to Carry Emergency Medication

**Provider approval for self-carry/self-administration of medication: _____Yes _____ No**

Please circle medication for self-carry/self-administration: Metered Dose Inhaler, EPI Pen, Diazepam or other, list here: ____________________________________.

## Provider Signature for Order

→_______________________________________________________ **Date:** ____/____/______

Signature of Prescribing Healthcare Professional

**Prescriber's Printed Name:** ______________________________________________________________

**Clinic Name/Address**: ___________________________________________________________________

**Phone:** (______) ________-___________ **Fax:** (______) ________-__________

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Padre/Guardián: lea y firme abajo. Doy mi consentimiento para que el personal de la escuela administre los medicamentos mencionados anteriormente según sea autorizado por el proveedor de salud. Estoy de acuerdo en notificar al Centro de Salud para Estudiantes directamente al finalizar esta solicitud o cuando algún cambio de esta orden sea requerida. Autorizo a la enfermera escolar en contactar al médico directamente para aclarar esta orden o para reportar cualquier reacción adversa o efecto secundario. Entiendo que puede ser necesario compartir esta información con otro personal de la escuela para garantizar la administración adecuada de este medicamento. Esta información también puede compartirse con el personal médico de emergencias en caso de una emergencia que requiera transportación a un centro médico. Al final del año escolar, entiendo que debo recoger los medicamentos no usados del Centro de Salud para Estudiantes o que serán descartados adecuadamente al fin del año escolar.

__________________________________________________________ _______/_______/________

Firma del padre/guardián Fecha