SCHOOL DISTRICT OF WAUKESHA

Authorization to Administer Prescribed Medication

Student _____ Birth date _____

School _____ Grade _____ School Year _____

Parent/Guardian 1: _____ Parent/Guardian 2: _____

Daytime Phone (____) _____ Daytime Phone (____) _____

Cell (____) _____ Cell (____) _____

Authorization expires at the end of the school year or following the summer school session.

Parent/Guardian Medication Consent:

I give permission for my son/daughter to receive the medication listed below. I also give permission for an exchange of information between school district personnel and the health care provider, if necessary, regarding this medication. I agree to notify the school in writing at the withdrawal of this request or when a change in this medication occurs.

I understand that it is my responsibility to:

- Transport the medication to school in the original *pharmacy-labeled* container
- Replace the supply of medication when needed
- Pick up medication or direct staff to discard remaining medication upon discontinuation or at the end of the school year

Parent/Guardian Signature _____ Date _____

Health Care Provider's Order for Medication to Be Given at School

Medical Condition:	
Name of Medication: (generic and trade)	
Dosage of Medication:	_____mg / cc / tsp _____ drops / puffs Form: ☐ Tablet / Capsule ☐ Liquid ☐ Inhaler ☐ Nebulizer ☐ Other _____
Route:	☐ Oral ☐ Eyes ☐ Ear ☐ Nose ☐ Topical ☐ Rectal ☐ Other _____
Administration Time:	☐ **Daily at:** _____ ☐ **As needed** – Describe frequency & symptoms for which medication should be given: _____ ☐ May be repeated in _____ minutes/hours. (time)
Possible Side Effects:	
For inhaled asthma medication ONLY:	☐ In my professional opinion, this student should be allowed to carry and use this medication by him/herself. ☐ In my professional opinion, this student ***SHOULD NOT*** carry this medication by him/herself.

Health Care Provider's Name (Please print) _____ Phone (____)_____

Health Care Provider's Signature _____ Date _____

FOR SCHOOL USE ONLY

- Date received: _____
- Name of person(s) who will administer the Medication:

  _____ _____

- Approved by: _____ _____
  (Principal's Signature) (Date)
- _____ Referred for administrative review. Send to School District Nurse with your concerns about this authorization.