



NORTH FOND DU LAC SCHOOL DISTRICT

School Health Programs

Friendship Learning 920-929-3757/ fax 920-929-7020
Bessie Allen: 920-929-3754/ fax 920-929-3747
Horace Mann: 920-929-3740/ fax 920-929-3745

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MEDICATION AUTHORIZATION

Student: _____ Grade: _____ Date: _____

Date of Birth: _____ School: _____ Teacher: _____

All Medications administered by NFDL staff are only available to students during school hours (7:30 a.m. - 4 p.m.), must not be expired, and in a properly labeled pharmacy box/bottle. Ask your pharmacy for any needed labels or containers

Section 1: Prescription Medications (Provider Signature Required on Page 2)

Medication Name/Strength	Dose	Route*	Time	Reason/Diagnosis	Expiration Date

*Route=oral, inhaled, topical, injectable, etc.

Section 2: Over-the-Counter (OTC) Medications

Medication Name/Strength	Dose	Route*	Time	Reason/Diagnosis	Expiration Date

*Route=oral, inhaled, topical, injectable, etc.

INHALERS:

- ☐ Totally independent (Has been trained by physician on use and is prepared to self-administer)
☐ Inhaler is kept by designated school personnel and used under supervision
☐ Other: _____

**Grades 4K-5 store inhalers in the school health room (independently use inhaler at discretion of MD/parent). Grades 6-12 are able to self carry/administer with the signature of a physician.*

Parent Consent for Medication Administration

I hereby give my permission to the person(s) designated by the building administrator or designee, to give the above medication(s) to my child according to the directions stated above and further authorize them to contact and share medical information about my child with the physician indicated below. I agree to hold the North Fond du Lac School District and its employees who are acting within the scope of their duties harmless from any and all claims arising from the administration of this medication. I agree to pick up any remaining medication by the last day of school or will give the school authorization to dispose of all remaining medication(s). I understand that a completed and signed Medication Administration Consent form is required before a prescription drug can be administered. This information will be shared with NFDLSD staff on a need-to-know basis for the health and safety of my child.

Parent/Guardian Signature: _____ Date: _____



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The Physician Information/Consent section must be completed whenever the following conditions exist:

- Any OTC medication product that contains aspirin;
- An OTC medication is to be given daily for greater than 10 days in a row;
- An OTC medication is to be given in a dosage other than the recommended therapeutic dose; or
- Any prescription medication

**Any medication/substance that is not FDA-approved may not be given by NFDLSD staff.
Expired medications may not be given by NFDLSD staff**

Health Care Provider Authorization:

I am prescribing the following medication and procedures for the above student to be administered or performed at school. **I hereby give permission to the persons designated below to give medication(s) to my child according to the directions stated above and further authorize them to contact the child's physician. I agree to hold the North Fond du Lac School District, its employees and agents who are acting within the scope of their duties harmless (Wisconsin Statutes 118.29 (2)(a)(1)(2)(3)(b).)**

Provider Information/Consent

Print Name of Provider _____ Clinic Name _____
Phone Number _____ Fax Number _____
Address _____
Signature of Provider _____ Date _____

***Note to Health Care Provider: This document serves as medication and treatment orders**

PLEASE NOTE: The above orders shall be effective throughout the current school year, summer school and through September 30th of the following school year, unless the orders are discontinued, changed or withdrawn in writing by the parent/guardian before that time elapses.