NORTH FOND DU LAC SCHOOL DISTRICT
School Health Programs
305 McKinley Street, North Fond du Lac, WI 54937

Schools:
Early Learning: 920-929-3762/fax 920-322-9117
Friendship Learning 920-929-3757/fax 920-929-7020
Bessie Allen: 920-929-3754/fax 920-929-3747
Horace Mann: 920-929-3740/fax 920-929-3664

MEDICATION AUTHORIZATION

Student's Name: _____ Date of Birth: _____
School: _____ Grade: _____ Home Phone number: _____

Prescribing Doctor: _____ MD phone:_____ MD Fax:_____
Diagnosis: 1._____ 2. _____

Parent Permission

I am requesting that my child, _____, receive prescription or over-the-counter medication at the time indicated and as designated by his/her medical provider. If a prescribed medication is needed at school, a physician's signature is also needed. All over the counter medications only need a parent's signature unless the dose is different than what is recommended on the bottle.

I will be responsible for bringing the prescription drugs to school in a labeled container from the pharmacist. I also understand that I am responsible for maintaining a sufficient quantity of the medication or supplies at the school. Failure to do this will result in an interruption of the physician's order or discontinuation of the school's administration of the medication/procedure for my child. I understand that, if my child refuses to take the medication(s) , force will not be used by school personnel to make my child comply.
School personnel have permission to communicate with the prescribing medical provider regarding use, side effects, response, and contraindications of the medication(s) or the procedure results or frequency. I can rescind my permission at any time.

_____ _____ _____
Parent/Guardian Name **Address** **Telephone**

_____ _____ _____
Signature of Parent/Legal Guardian **Relationship** **Date: (Mo./Day/Yr.)**

DAILY

Name of Daily Medication (Generic and Trade Name)	Dosage/ Frequency	Time(s) (AM/PM):	Start date	Stop date	Possible Adverse Side Effect or Contraindications:

PRN (AS NEEDED)

Name of PRN Medication (Generic and Trade Name)	Dosage/ Frequency	Time(s) (AM/PM):	Start date	Stop date	Possible Adverse Side Effect or Contraindications:

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 school health room (independently use inhaler at discretion of MD/parent). Grades 6-12 are able to self carry/administer with signature of physician.*

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.

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).)

_____ _____ _____
Medical Provider's Signature Address Date (Mo./Day/Yr.)