



**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.

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.

_____	_____	_____
<b>Parent/Guardian Name</b>	<b>Address</b>	<b>Telephone</b>
_____	_____	_____
<b>Signature of Parent/Legal Guardian</b>	<b>Relationship</b>	<b>Date: (Mo./Day/Yr.)</b>

**Health Care Provider Authorization:**

I am prescribing the following medication and procedures for the above student to be administered or performed at school.

**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 30<sup>th</sup> of the following school year, unless the orders are discontinued, changed or withdrawn in writing by the parent/guardian before that time elapses.**

**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.)