Policy 5330 F2 Revised 6/07
Health Services ♦ 4800 South 60th Street ♦ Greenfield, Wisconsin ♦ 53220 ♦ 414-281-6200 ♦ FAX 414-281-8860

AUTHORIZATION TO ADMINISTER NONPRESCRIPTION MEDICATION

Complete *one form for each medication.* Guidelines on Reverse Side ⇨

PLEASE PRINT

School Year: _____ School: _____Grade: _____ Room: _____ Teacher: _____

Student: _____ Date of Birth: _____Home Phone: _____

Parent/Guardian: _____ Work Phone: _____ Cell Phone: _____

I, the parent or legal guardian of the above named student, have read and understand the Medication Guidelines on the reverse side. I understand that medications are NOT given by licensed medical professionals but by designated trained school personnel. I give my permission for designated school personnel to administer to my child the nonprescription (over the counter or OTC) medication listed below according to my written instructions. I further give permission for designated school personnel to request and share relevant health information about my child and the administration of this medication with appropriate school personnel.

I agree to:

- Deliver or assume responsibility for safe delivery of the medication to school.
- Provide the medication in the original, labeled, unopened manufacturer's container with my child's name clearly written on it.
- Submit a new written authorization form if any change in taking this medication occurs.
- Notify the school in writing immediately if there is a discontinuation of this medication.
- Pick up any unused medication

Medication:_____ Strength:_____

Taken for: _____Amount to be given:_____

Time(s) to be given: _____

How often to be given: _____

If given ***as needed*** state specific symptoms or conditions for which it is to be given: _____

_____

Parent/Guardian Signature: _____ Date: _____

"Children are the highlights of our lives"