



NORTHERN OZAUKEE SCHOOL DISTRICT

2008-09

MEDICATION AUTHORIZATION

PARENT/GUARDIAN FORM



List one medication per form

Please print:

STUDENT \_\_\_\_\_ BIRTH DATE \_\_\_\_/\_\_\_\_/\_\_\_\_ GRADE \_\_\_\_

Medication name \_\_\_\_\_

Dose \_\_\_\_\_ Method of administration \_\_\_\_\_

Time/Frequency \_\_\_\_\_ Start date \_\_\_\_\_ End date \_\_\_\_\_

Reason for medication \_\_\_\_\_

If "as needed," conditions under which prescribed medication should be given: \_\_\_\_\_

Precautions, possible undesirable reactions, and/or interventions: \_\_\_\_\_

Is this medication prescribed by a physician?  Yes\*  No

\*IF YES, HAVE PHYSICIAN COMPLETE THE REVERSE SIDE. PRESCRIPTION MEDICATION WILL NOT BE ACCEPTED WITHOUT THE REVERSE SIDE COMPLETED OR A SEPARATE, SIGNED PHYSICIAN ORDER.

Physician's name \_\_\_\_\_ Phone number (\_\_\_\_) \_\_\_\_\_

- I give my permission to school personnel to give this medication to my child according to the preceding directions and to contact my child's physician, if necessary.
If this medication is injectable, school employees who have been trained in techniques of administering subcutaneous or intramuscular injections have my permission to administer it.
MEDICATIONS MUST BE BROUGHT TO SCHOOL BY A RESPONSIBLE ADULT IN THE ORIGINAL CONTAINER OR THEY WILL NOT BE ACCEPTED.
I agree to hold the school district and personnel harmless in any claims arising from administration of this medication at school.
I agree to notify the school in writing when any change in the preceding medication/orders is necessary.

Parent/guardian signature \_\_\_\_\_

Date \_\_\_\_\_

SCHOOL USE ONLY

To be completed by school principal

I designate the following employees as authorized to administer this medication:

- 1st \_\_\_\_\_
2nd \_\_\_\_\_
3rd \_\_\_\_\_

Principal's signature \_\_\_\_\_

NORTHERN OZAUKEE SCHOOL DISTRICT

2008-09

MEDICATION AUTHORIZATION

PHYSICIAN FORM



List one medication per form

Date \_\_\_\_\_

Permission is granted for school employees (as designated by school principal) to administer medication as follows:

STUDENT \_\_\_\_\_ BIRTH DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

Medication name \_\_\_\_\_

Dose \_\_\_\_\_ Method of administration \_\_\_\_\_

Time/Frequency \_\_\_\_\_ Duration \_\_\_\_\_

Diagnosis \_\_\_\_\_

Precautions, interventions, comments: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I am willing to be contacted by school personnel with concerns or questions involving this medication administration.

If the medication is injectable, school personnel (as designated by principal) who have been trained in techniques of administering subcutaneous or intramuscular injections have permission to administer the injectable medication.

**Medications must be brought to school in the original container by a responsible adult.**

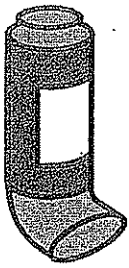
Please print:

\_\_\_\_\_  
Physician's name ( ) Phone number

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, state, ZIP

\_\_\_\_\_  
Physician's signature Date



NORTHERN OZAUKEE SCHOOL DISTRICT

Authorization for Self-Carry/Administration of Medication at School and After School Activities



School Board policy permits a responsible, trained student to carry and/or self-administer medication for asthma (wheezing) or severe allergic (anaphylactic) reaction on his/her person for immediate use in a life-threatening situation with written order of physician, parent request, school nurse, and principal approvals.

PHYSICIAN/PRESCRIBING HEALTH CARE PROVIDER

Date: \_\_\_\_\_

STUDENT \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_ GRADE: \_\_\_\_\_

MEDICATION NAME \_\_\_\_\_

DOSE \_\_\_\_\_ METHOD OF ADMINISTRATION \_\_\_\_\_

TIME/FREQUENCY: \_\_\_\_\_

DURATION (DATES) OF ADMINISTRATION: FROM \_\_\_\_\_ To \_\_\_\_\_ (LIMIT OF ONE SCHOOL YEAR)

DIAGNOSIS \_\_\_\_\_

PRECAUTIONS, INTERVENTIONS, COMMENTS: \_\_\_\_\_

IN MY OPINION, THIS STUDENT SHOWS CAPABILITY TO CARRY AND SELF-ADMINISTER THE ABOVE MEDICATION.

Physician's signature \_\_\_\_\_ Print name \_\_\_\_\_ Phone number \_\_\_\_\_ Fax number \_\_\_\_\_

Address \_\_\_\_\_

City, state, ZIP \_\_\_\_\_

Parent/Guardian Authorization

I request that my child, named above, be permitted to \_\_\_\_\_ carry \_\_\_\_\_ self-administer the above ordered medication. I take responsibility for this permission. I understand that the medication must be in the original pharmacy container, labeled with name of student, prescribing health care provider, and medication; date of original prescription; strength and dose of medication; and directions for use. This medication will be destroyed unless picked up within one week after the end of the school year or end of the medical order.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_ Student Signature \_\_\_\_\_ Date \_\_\_\_\_

We accept the parent request and physician statement. We will permit and assist the student to be responsible, but reserve the right to withdraw the privilege if the student shows signs of irresponsible behavior or there is a safety risk. We will contact the parent as soon as possible in this event.

School Nurse Signature \_\_\_\_\_ Date \_\_\_\_\_ Principal Signature \_\_\_\_\_ Date \_\_\_\_\_