MENOMONEE FALLS SCHOOLS
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Authorization to Administer Prescription Medication

Student _____ **Birth date** _____

School _____ **Grade** _____ **School Year** _____

Parent/Guardian 1: _____ **Parent/Guardian 2:** _____

Daytime Phone#: _____ **Daytime Phone #:** _____

Cell Phone #: _____ **Cell Phone #:** _____

Authorization expires at the end of the school year or following the summer school session.

Parent/Guardian Medication Consent:

I give permission for my child to receive the medication listed below. I also give permission for an exchange of information between school district personnel and the health care provider, if necessary, regarding this medication. I agree to notify the school in writing at the withdrawal of this request or when a change in this medication occurs.

I understand that it is my responsibility to:

- **Transport the medication to school in the original *pharmacy-labeled* container (4K through 8th grade)**
- Replace the supply of medication when needed
- Pick up medication or direct staff to discard remaining medication upon discontinuation or at the end of the school year

_____ _____

Parent/Guardian Signature *Date*

Health care Provider's Order for Medication to be Given at School

Medical Condition:	
Name of Medication: (generic and trade)	
Dosage of Medication:	_____ mg cc tsp _____ drops puffs Form: Tablet / Capsule Liquid Inhaler Nebulizer Other
Route:	Oral Eyes Ear Nose Topical Rectal Other:
Administration Time:	**Daily at:** _____ **As needed** – Describe frequency & symptoms for which medication should be given: _____ May be repeated in _____ minutes/hours. *(time)*
Possible Side Effects:	
For inhaled asthma medication ONLY:	In my professional opinion, this student should be allowed to carry and use this medication by him/herself. In my professional opinion, this student ***SHOULD NOT*** carry this medication by him/herself.

Health Care Provider's Name *(please print)* _____ Phone #: _____

Health Care Provider's Signature _____ Date _____