SCHOOL DISTRICT OF MENOMONEE FALLS
Pursuing Excellence One Student at a Time

Authorization to Administer Over-the-counter *(non-prescription)* Medication

Student _____ Birthdate _____

School _____ Grade _____ School Year _____

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

Daytime Phone (_____) _____ Daytime Phone (_____) _____

Cell (_____) _____ Cell (_____) _____

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

Parent/Guardian Consent:

I give permission for my son/daughter 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 container/packaging or a *pharmacy-labeled* container (4K-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 _____

- NOTE: An Authorization to Administer Prescribed Medication form is required if:
  - ***the medication contains a narcotic*** *(usually prescribed for pain)* **OR**
  - *the medication dosage exceeds the manufacturer's recommendation* **OR**
  - *a short-term prescription medication is needed for more than 2 weeks*

Reason:		
Name of Medication: **(generic and trade)**		
Dosage of Medication:	_____ mg / cc / tsp _____ drops / puffs	Form: ☐ Tablet / Capsule ☐ Liquid ☐ Ointment / Cream ☐ Inhaled ☐ Eye / Ear / Nose Drops
Route:	☐ Oral ☐ Eyes ☐ Ear ☐ Nose ☐ Topical	
Time to be given:	☐ **As needed** – Describe frequency & symptoms for which medication should be given: _____ ☐ May be repeated in _____ minutes/hours. (time)	

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FOR SCHOOL USE

- Date received: _____
- Name of person(s) who will administer the Medication:

  _____ _____

- Approved by: _____ _____
  (Principal's Signature) (Date)
- _____ Referred for administrative review. Send to School District Nurse with concerns about this authorization.