Mequon Thiensville SCHOOL DISTRICT

Authorization to Dispense Prescription / Non-Prescription Medication(s)

☐ **Donges Bay Elementary**: Phone: (262) 238-7920 Fax: (262) 238-7970
☐ **Oriole Lane Elementary:** Phone: (262) 238-4220 Fax: (262) 238-4250
☐ **Wilson Elementary:** Phone: (262) 238-4600 Fax: (262) 238-4662
☐ **Steffen Middle School:** Phone: (262) 238-4700 Fax: (262) 238-4740
☐ **Lake Shore Middle School:** Phone: (262) 238-5900 Fax: (262) 238-5633
☐ **Homestead High School:** Phone: (262) 238-5900 Fax: (262) 240-4156

Student Name: _____ Grade: _____ Birthdate: _____ Date:_____ _

Important Guidelines:

Physician Signature is required *for: all prescription medications; any over-the-counter medication above the manufacturer's recommendations.*

A signed **Emergency Care Plan** form must accompany this authorization for prescribed epinephrine auto-injector, rescue inhaler, anti-seizure medication, anti-diabetic medication, and/or Glucagon.

Herbal, vitamin or nutrition supplements, and any medications administered regularly at school for longer than ten days also require a physician signature.

All medication must be presented to school in original packaging. Prescription label must match instructions from prescriber. Medication may not be expired. New forms and medication must be provided each year. New forms must be provided for any changes.

Name of Medication	*OTC or Rx?	Dosage (amount)	Time	Route (oral, etc.)	Reason	Start Date	Stop Date

**Please write "OTC" for over-the-counter or "Rx" for prescription medication.*

PARENT / GUARDIAN AUTHORIZATION FOR MEDICATION(S) LISTED ABOVE

I give consent for designated school personnel to administer the above listed medication/s as indicated during the school day. I agree to hold the Mequon Thiensville School District and its employees harmless in any and all claims arising from the administration of this/these medication(s) at school. I agree to notify the school in writing at the termination of this authorization or when any changes in the above order are necessary. I understand that school staff may contact me with any concerns regarding medication administration. I give permission for the school's designated health care professionals to contact my child's physician with any concerns regarding medication administration. I understand that I, the parent, must pick up any unused medications at the end of the school year or the medication will be discarded.

☐ *I give my student permission to self-carry (only applies to OTC medications for students in 9-12 grade)*

_____ _____ _____/_____/_____

Signature of Parent/Guardian Phone Number Date

PHYSICIAN AUTHORIZATION FOR PRESCRIPTION MEDICATION(S)

Note: Before medication(s) prescribed by a physician can be administered by school personnel, a signed statement from the physician must be on file and must include (a) the conditions and circumstances for administering the medication(s), (b) the prescribed dosage, and (c) the frequency of administration. The medication instructions above may be used for this purpose. In addition:

- Prescribed medication(s) are to be administered to this student who has a diagnosis of_____.
- In the event that the medication administration is missed by more than one hour, I instruct the following:

_____

- Additional instructions/comments:

_____ _____/_____/_____ Date

Signature of Physician or Healthcare Provider with Prescriptive Rights

Print Physician Name: _____ Physician's Phone: _____

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District Nurse Signature of Review:_____ Date: _____ Entered ☐