MEQUON-THIENSVILLE
SCHOOL DISTRICT

Parent/Guardian Authorization Form for Administering Medication

Student Name:		DOB:
School:	Grade:	School Year:
Physician Name:		Physician Phone:

Physician signature is required for:
1) All Prescription Medications 2) Any over the counter above the recommended dose on container

Medication Name	Dose	Route	Time to be given	Reason	Stop date

- ☐ I hereby give permission for MTSD's trained staff to give the medication to my child according to the directions stated above. I agree to hold MTSD, it's employees and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication at school.
- ☐ I give permission for the school staff, including the district designated health care professionals, to contact my child's physician with any concerns regarding medication administration.
- ☐ I give the school staff, including the district designated health care professionals, permission to call me with any concerns regarding medication administration.

- Medication must be brought to school in the original packaging
- Medication may NOT be expired
- Only students in grades 9-12 may carry and self-administer **over the counter** medications with this signed form on file and school nurse approval

_____ _____ _____
Parent Signature Phone # Date

➡ _____ _____ _____
Physician Signature Phone # Date

By signing this form, I , the physician, am stating I have reviewed and agree with the plan of having the school administer the named medication(s) to the student specified on this form

To be completed by School Nurse

☐ *I am herein designating the trained school personnel to administer the medication as prescribed above to the student indicated on this form:*

☐ *The student (grades 9-12 only) may carry and self-administer the above over the counter medication*

_____
School Nurse signature *updated 2017*