Mukwonago Area School District

Authorization to Administer ***Non-Prescription*** Medication

Student _____ Birth Date (mm/dd/yyyy) _____

School Choose A School _____ Grade Choose A Grade _____ School Year Choose a School Year

Parent/Guardian _____ Daytime Phone (xxx-xxx-xxxx) _____ Cell Phone (xxx-xxx-xxxx) _____

Health Care Provider Name _____ Phone (xxx-xxx-xxxx) _____

Health Care Provider Address_____

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

Medical Condition:	
Name of Medication:	
Form of Medication:	◯ Tablet / Capsule ◯ Drops ◯ Liquid ◯ Spray ◯ Other _____
Medication Strength: **(How many MG per Tablet / ML / tsp)**	
Dose of Medication: **(How much should we give)**	_____ ◯ mg ◯ ml / cc ◯ tsp ◯ Other _____
Administration Time:	☐ **Daily at:** _____ ☐ **As needed** (Describe frequency & symptoms for which medication should be given) _____ ☐ May be repeated in _____ (Time) ◯ minutes ◯ hours
Possible Side Effects:	
Self-Carry / Self-Administer: **Grades (7 - 12)**	◯ My son/daughter **CANNOT** self-carry or self-administer this medication at school. ◯ My son/daughter can self-carry and self-administer this medication at school.

Parent/Guardian Medication Consent:

I give permission for my son/daughter to receive the medication listed above by designated school personnel. I understand that MASD and the school personnel administering the above medication is not liable for any adverse reaction suffered as a result of administration. My child has taken the above medication previously and has not experienced an adverse reaction. 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 for 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** sealed manufacture's package with the list of ingredients and recommended therapeutic dose.
- 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** _____

Fax Numbers:

Big Bend 262-662-1309	Clarendon 262-363-6289	Eagleville 262-594-5495	Prairie View 262-392-6312
Rolling Hills 262-363-6343	Section 262-363-6341	Park View 262-363-6320	Mukwonago High 262-363-6239

District Nurse Phone: 262-363-6292 x27515 Fax: 262-363-6320

Entered in Infinite Campus By: _____ Date: _____ 05/2012 by LAH