# Mukwonago Area School District

## Authorization to Administer ***Prescription*** Medication

Student _____ Birth Date _____

School _____ Grade _____ School Year _____

Parent/Guardian _____ Daytime Phone (____)_____ Cell (____)_____

Health Care Provider Name _____ Phone (____) _____

Health Care Provider Address_____

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

**Parent/Guardian Medication Consent:**

I give permission for my son/daughter to receive the medication listed below by designated school personnel. I understand that MASD and the school personnel administering the medication below is not liable for any adverse reaction suffered as a result of administration. My child has taken the medication below 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** *pharmacy-labeled* container; and the container specifies the students name, name of prescriber, the name of medication, the dose, the effective date, and the directions for administration.
- Replace the supply of medication when needed.
- Pick up 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

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|---|---|
| **Medical Condition:** | |
| **Name of Medication:** | |
| **Form of Medication:** | ☐ Tablet / Capsule ☐ Inhaler ***(Inhaler for Asthma: See Asthma Care Plan)***<br>☐ Liquid ☐ Drops ☐ Spray ☐ Other _____ |
| **Medication Strength:**<br>**(How many MG per Tablet / ML / tsp)** | |
| **Dose of Medication:**<br>**(How much should we give)** | _____ mg _____ ml / cc _____ tsp Other _____ |
| **Administration Time:** | ☐ **Daily at:** _____<br>☐ **As needed** (Describe frequency & symptoms for which medication should be given)<br>_____<br>☐ May be repeated in _____ minutes / hours<br>(Time) |
| **Possible Side Effects:** | |
| **Self-Carry / Self-Administer:**<br>**Grades (7 - 12)** | ***Only Inhaler, Epinephrine, and over the counter prescription strength medication may be carried***<br>☐ In my professional opinion, this student should be allowed to carry and use this medication by him/herself.<br>☐ In my professional opinion, this student ***SHOULD NOT*** carry this medication my him/herself. |

**I accept direct communication from school personnel administering this medication at school or school sponsored event.**

*** Health Care Provider's 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: _____ Revised 11/2015 by LAH