AUTHORIZATION FOR
NONPRESCRIPTION & PRESCRIPTION DRUG PRODUCTS OR TREATMENT

The Kewaskum School District will not provide aspirin, Tylenol or other over the counter medicine to students. If your child needs anything for headaches, cramps, etc, please bring a supply (in the original manufacturer's container) to the office along with this form.

Student Name: _____ Date of Birth: _____

NONPRESCRITION MEDICATION

Medication Name:_____

Dosage:_____

Time to be given:_____

Reason for taking medication:_____

PRESCRIPTION MEDICATION

The medication must be in the original pharmacy labeled package with the following information in a legible format: student's name, practitioner's name, date, pharmacy name and telephone, name of medication, prescribed dosage and frequency, and special handling and storage instructions.

Medication Name:_____

Time to be given:_____Begin Date: _____End Date:_____

Dosage:_____

Reason medication is being prescribed:_____

Possible side effects:_____

_____

Date_____Physician's Signature_____

Physician's Address: _____ Telephone No: _____

PARENT AUTHORIZATION

I authorize the above medication to be given as indicated to my son/daughter.

I will assume responsibility for safe delivery of the medication to school and I authorize the above medication to be given as indicated to my son/daughter. I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment. I release and agree to hold the Board of Education, its officials, and its employees harmless from any, and all, liability for damages or injury resulting directly or indirectly from this authorization.

Date_____Parent/Guardian Signature_____