

Green Bay Public School District

Medication Authorization Form



Form is to be used for one medication only. Each medication requires a separate form. All portions of the medication form must be completed for before medication can be administered by school district staff. Form needs to be filled out completely or it will be returned and medication will not be able to be given.

Student: _____ School: _____

Date of Birth: _____ Grade: _____ Name of Medication: _____

Dose: _____ Time(s) to be given: 1. _____ 2. _____ 3. _____

Method: (please circle) Oral Inhaled Nebulizer Injectable Topical Eye Ear Other: _____

Give: (please circle) Daily or As Needed Dates to be given: From: _____ to: _____

If medication is to be given As Needed, write the circumstances for which it should be used:

Comments:

Parent/Guardian Consent: *Complete for ALL Medication/Procedures at School*

- ▶ I request and authorize that school staff administer this medication or perform this procedure at school.
- ▶ I will supply medication in its original, updated, properly labeled container. (An extra bottle can be requested from the pharmacy)
- ▶ If medications are for a field trip, I will send only the quantity that will be needed during the duration of the trip / camp.
- ▶ This authorization is for the entire school year unless otherwise indicated.
- ▶ I will obtain a new physician's order and notify the school in writing for any changes.
- ▶ I authorize the school nurse to exchange information verbally or in writing with my child's physician regarding this medication/procedure or conditions for which it is prescribed.
- ▶ I understand that all medication is to be transported to and from school by parent/guardian.
- ▶ I understand that non-medically licensed school staff will be giving medication, performing procedures, & completing routine medication counts.
- ▶ I agree to hold the Green Bay Area Public School District, its 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.
- ▶ My signature indicates that I have fully read and understand the above information.

ASTHMA INHALERS: *This student is capable of self-administration and may carry inhaler* Circle: YES or NO

EPI PENS ONLY *Student may self-carry epi-pen.* Circle: YES or NO

Signature of Parent or Guardian: _____ Date: _____

Daytime Telephone Number: _____

Physician Authorization: *Required for all Prescription Medication/Food Supplements/Over-the-Counter Medications that exceed the recommended packaging dose. Required for treatments or procedures needed to be done at school.*

ASTHMA INHALERS: This student is capable of self-administration and may carry inhaler: Circle: YES or NO

EPI PENS ONLY: Student may self-carry epi-pen. Circle YES or NO

The above medication is to be administered during the school day. I understand that medication/treatment will be given by non-medically licensed staff that has been trained to do such. Further written instruction will follow from me if the drug is to be discontinued or the dosage or administration time is changed from these instructions.

Symptoms/Side Effects of Medication:

Health Care Providers Signature (no stamp): _____ Date: _____

Name of Physician (Printed): _____ NPI Number: _____

Physician Fax Number: _____ Telephone Number: _____