NORTH LAKE SCHOOL
MEDICATION ADMINISTRATION AUTHORIZATION FORM

*This form pertains to Physician/Practitioner prescribed medication **and** over-the-counter medications.*

Box 1 – Practitioner Prescribed Medication - Your Practitioner needs to fill out the top portion and the info in Box 1 with any prescribed medications that may be administered during the school day/activities. He/She needs to sign and date the bottom in the Prescribed Medication Section. (Please note – EPIPEN and INSULIN require an additional form).

Box 2 – Over the Counter – Parents need to fill out the top portion and the information in Box 2 for administration of all over-the-counter medications. Non-prescription medication will only be administered in accordance with product instructions. If the student requires dosing different than manufacturer's instructions, a practitioner order AND signature is required. Remember to include **all** of the information: Route (oral, inhalation, topical, etc.), Dose (mg, ml), Frequency (as needed, every 4-6 hours, etc.), Duration (indicate dates). If it is not filled out completely, meds cannot be given (according to WI state statutes). Parents need to sign the form if **any** of this section is filled out, acknowledging accuracy and releasing North Lake School from any liability, and give consent for school to contact Practitioner if need arises. One form needs to be filled out for **each** student at North Lake School.

Please administer the following medication(s) to:

Name of Student	DOB	Height	Weight	Grade

Diagnosis(s)	Allergies

Current medication taken at home:

BOX 1 - PRACTIONER PRESCRIBED MEDICATION:

☐ Please check box if student may self-carry inhaler.

☐ Please check box if student may self-carry epi-pen. (If self-carrying, we still need an epi-pen in health room.)

Name of Medication	Route	Dose	Frequency	Duration	Direct contact shall be made with MD/NP should the student receiving the medication develop any of the following conditions or reactions to the medication (if none, so state)
				From: To:	
				From: To:	
				From: To:	

Hospital/Clinic/Office — Phone Number:

Address Street, City, State, Zip — Fax Number:

Physician's Signature (required for MD/NP prescribed medicine) **Date:**

BOX 2 - OVER-THE COUNTER/AS NEEDED MEDICATION:

Name of Medication	Route	Dose	Frequency	Duration	Condition under which medication should be given (i.e. pain, cough)
				From: To:	
				From: To:	
				From: To:	

★When administering: ☐ Please call before/after (circle one) ☐ Email ☐ Send note home ☐ Text Message – Phone # & Provider

Additional Information/Instructions

Parent's Signature	**Date:**

Guardian, please **check one** of the following statements:

_____ Authorized school personnel have my permission to administer the prescription and/or non-prescription medication(s) to my child as described above.

_____ My child has my permission to carry and self-administer the above prescription and/or non-prescription medication(s).

I AGREE TO HOLD THE NORTH LAKE 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 MEDICATION AS DESCRIBED ABOVE AT SCHOOL. I HEREBY GIVE PERMISSION TO THE SCHOOL NURSE TO CONTACT THE PHYSICIAN AS NEEDED.

I UNDERSTAND THAT FOR SAFETY REASONS, ALL MEDICATION (PRESCRIPTION OR NON-PRESCRIPTION) HAS TO BE IN THE ORIGINAL CONTAINER. I FURTHER UNDERSTAND IT IS MY RESPONSIBILITY TO INFORM THE SCHOOL NURSE OF ANY CHANGES TO MY CHILD'S MEDICATIONS.

Guardian Signature: _____ Date: _____

School Nurse Approval:_____ Date: _____

*This form is only valid for the current school year in which date signed falls within. Questions? 262-966-2033