Port Washington-Saukville School District

AUTHORIZATION TO ADMINISTER MEDICATION

PARENTAL CONSENT FOR NON-PRESCRIPTION MEDICATION

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Name of Student: _____ Date of Birth: _____

School: _____ Grade: _____

Names of Parent(s)/Guardian: _____

Phone: (Home) _____ (Work) _____

I give permission for my child to receive over-the-counter medication during school hours.

I will be responsible for:

1) 1) Delivery of medication in an **original manufacturer's labeled container** to the school office
2) 2) Maintaining a sufficient supply of medication
3) 3) Keeping school personnel informed of changes in the medication (dosage, time)

I hereby release the Board of Education and its agents and employees from any and all liability that may result from my child taking the prescribed medication.

_____ _____

(Parent/Guardian Signature) (Date)

Name of Medication (Generic and Trade)	**Dosage** (mg/cc/tsp/gtt)	**Form*** (tab/cap/liq)	**Time** a.m./p.m.	**Possible Side Effects**

**Prior to administration of medication by routes other than oral, school personnel must contact the school district nurse for instruction.*

I understand the above information may be shared by the school principal with necessary school personnel. The above request shall remain in effect through _____, unless parent/guardian withdraws the request in writing.

(Date)

For School Use Only

1. 1. Date Received: _____

2. 2. Name of Person (s) who will administer the medication:

   _____ _____

3. 3. Approved by: _____ _____

   (Signature of Principal) (Date)