AUTHORIZATION TO ADMINISTER PRESCRIPTION AND OTC MEDICATION 2024-2025

Instructions: Medications, prescription and over the counter (OTC), are encouraged to be administered at home by the parent/guardian whenever possible. If it is necessary for a scholar to receive medications at school, on field trips, or a school sponsored activity, this form must be completed by a healthcare provider and parent/guardian before medication can be given at school. Please fill out one (1) form for EACH required medication. This includes over the counter medications (OTC).

Scholars' Name: ____________________________________ Date of Birth: _______________ Grade: _______

Parent Permission
I am requesting that my scholar, _____________________________________, receive over the counter and/or prescription drugs or procedures at the time indicated and as designated by his/her healthcare provider.

- I will be responsible for bringing the medication(s) to school in a labeled container from the pharmacist or store bought labeled bottle. The pharmacy label directions must match the healthcare provider's order.
- I also understand that I am responsible for maintaining a sufficient quantity of the medication or supplies at the school. Failure to do this will result in an interruption of the physician's order or discontinuation of the school's administration of the medication/procedure for my scholar.
- I understand that, if my scholar refuses to take the prescribed medication(s) or allow the procedure(s), force will not be used by school personnel to make my child comply.

School personnel have permission to communicate with the prescribing medical provider regarding use, side effects, response, and contraindications of the medication(s) or the procedure results or frequency. I can rescind my permission at any time.

____ ________________ ________________
Signature of Parent/Legal Guardian Relationship Date: (Mo./Day/Yr.)

Health Care Provider Authorization: I am prescribing the following medication and procedures for the above scholar to be administered or performed at school.

OTC, DAILY or **PRN**

Name of Daily Medication (Generic and Trade Name)	Dosage/ Frequency	Time(s) (AM/PM):	Start date	Stop date	Possible Adverse Side Effect or Contraindications:

The above orders shall be effective throughout the current school year and summer school, unless the orders are discontinued, changed or withdrawn in writing by the parent/guardian before that time elapses.

____ ______________ ______________________________
Medical Provider's Signature Date (Mo./Day/Yr.) Telephone/Fax Number

____ ____
Printed Medical Provider's Name Address

608 Henry Avenue, Beloit, WI 53511
(608) 690-5100