Northern Ozaukee School District

Authorization for Prescription Medication

Date _____

Student_____ Date of Birth _____ Grade _____

School _____

To School Personnel:

I am requesting that my child, _____, receive prescription medication in school at the time indicated below by his/her physician.

I will be responsible for bringing the prescription medication to school in a labeled container from the pharmacist. I also understand that I am responsible for maintaining a sufficient supply of the medication at the school to avoid any interruptions in the physician's orders.

I understand that if my child refuses the medication, force will NOT be exerted by school personnel to make him/her comply. The school will notify parents of this refusal. I also understand that the information regarding prescription medication will be shared by the school principal/designee with appropriate NOSD personnel.

_____ _____

Parent/Guardian Signature Date

To School Personnel:

I am prescribing medication for _____which is described as follows:

Name of Medication	Dosage	Time (am/pm)	Possible Side Effects
(1)			
(2)			

Special Instructions_____

_____

I understand that the above orders will be shared by the school principal/designee and other NOSD personnel.

The above orders shall be effective through _____ unless they are discontinued, changed by me or withdrawn in writing by the parent/legal guardian.

_____ _____

Physician Signature Print Name

_____ _____

Phone Number Date