Northern Ozaukee School District
"Over the Counter" Medication Authorization
Parent/Guardian Form

Specify one medication per form

Date ______________________

Student_______________________________________ Date of Birth ________________ Grade _________

Medication Name____

Dose ___________________________________ Method of Administration _________________________

Time/Frequency ____

Duration (dates) of Administration: from ___________________ to __________________(limit of one school year)

Reason for Medication____

Precautions, Interventions, Comments____

- Medications must be brought in to school by a responsible adult in the original container.
- I give my permission to school personnel to give this medication to my child according to the preceding directions and to contact my child's physician if necessary.
- If this medication is injectable, school employees who have been trained in techniques of administering subcutaneous or intramuscular injections have my permission to administer it.
- I agree to hold the school district and personnel harmless in any claims arising from the administration of this medication at school.
- I agree to notify the school in writing when any change in the preceding orders is necessary.

____ __________________________

Parent/Guardian Signature Date

The District nurse or any staff member trained to administer medications is authorized to administer this medication.

____ __________________________

Principal Signature Date