Lake Country School District
1800 Vettelson Road • Hartland, WI 53029 • Phone: (262) 367-3606 • Fax: (262) 367-3205

Authorization of Medication for Students

Please print or type:
Student Name ________________________________ Parent/Guardian ________________________________

Home Phone ____________________ Work Phone ____________________ Cell/Pager ____________________

Home Address ____

Teacher __________________________ Grade ________ Birthdate ________________ ☐ Male ☐ Female

Physician's Name ____________________________________ Physician's Phone Number ____________________

TO THE PHYSICIAN: According to the State of Wisconsin Medical Examining Board and the Lake Country School District's *Administrative Guidelines for Dispensing Prescription and Nonprescription Medication to Students*, it is requested that you complete this form before school personnel may dispense or administer "Prescription" or "Over the Counter" medication. By signing this form, you indicate a willingness to accept direct communication from the person dispensing or administering the medication.

Name of Medication ____ Strength _________________________

FORM: ☐ Tablet ☐ Capsule ☐ Liquid ☐ Ointment ☐ Cream ☐ Lotion ☐ Inhaler ☐ Other

If *other*, please specify: ____

Time of day to be given ________________________ Length of time this medication is recommended ______________

If medication is being given "WHEN NEEDED," describe indications: ____

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Special instructions: ____

Side effects (expected or predictable): ____

Self-administration of medication by student: It is required that all medications be kept secure in the school health room and may be administered by designated school staff. No controlled substances may be kept or self-administered by the student. If a student needs to carry and self-administer certain emergency medication such as an asthma inhaler or epi pen, special permission will be granted with parent and physician authorization. Please specify if this student may carry and self-administer this medication. ☐ **YES** ☐ **NO**

PHYSICIAN SIGNATURE ____ DATE ____________________

****NOTE: OVER-THE-COUNTER MEDICATIONS DO NOT REQUIRE A PHYSICIAN'S SIGNATURE.**

TO THE PARENT/GUARDIAN: By signing below, you request and authorize that your son/daughter can be assisted in taking the medication described above at school by designated school staff. No controlled substances may be kept or self-administered by the student. If a student needs to carry and self-administer certain emergency medication such as an asthma inhaler or epi pen, special permission will be granted with parent and physician authorization. Please specify if the student may carry and self-administer this medication. ☐ **YES** ☐ **NO**

PARENTS ARE RESPONSIBLE FOR DELIVERING MEDICATIONS TO SCHOOL IN ORIGINAL CONTAINER.

I, the parent of the above named student, hereby release the Board of Education and its agents and employees from any and all liability that my result from my child taking the above medication.

PARENT/GUARDIAN SIGNATURE ____________________________________ DATE ____________________