Parent(s)/Guardian Medication Authorization Form
Over the counter medications

Student's Name: _____ Date of birth: _____

Address: _____ Grade: _____

As the parent and guardian of the above mentioned student, I give the

_____ School District permission to administer the following medication(s)

to my child for the following reason or diagnosis _____

_____.

Medication/Dosage (mg, cc, ml, etc)	How it is to be given	How often	Start Date	Stop Date	Considerations/ Side Effects
1.					
2.					
3.					

As the parent or guardian of the above mentioned student, I will keep the school district aware of any changes in medication(s) profile or health concern of my child.

As a part of the Wisconsin Statute Chapter 118.29, Administration of Drug to Pupils and Emergency Care, school districts are required to have permission from a medical provider and parent to administrator medications at school. As part of this authorization form, school district employees may contact the medical provider with questions regarding the medication administration including clarification regarding dosage, side effects or indication of the medication(s) listed above with parent permission.

Parent(s) Guardian Signature: _____ Date: _____