



PARENT/GUARDIAN MEDICATION AUTHORIZATION

Over-the-Counter (Nonprescription) Medication

STUDENT NAME	DATE OF BIRTH	GRADE
ADDRESS		SCHOOL
PARENT/GUARDIAN	PHONE	EMAIL

AUTHORIZATION

I authorize The School District of Glenwood City to administer the nonprescription medication(s) listed below to my child according to these written instructions and the school district's medication policy.

Medication / strength	Dose	Route	Start	Stop	Timing, reason, and side effects / special instructions

PARENT/GUARDIAN CONFIRMATIONS

- ☐ I supplied each medication in its original manufacturer's package, with ingredients and recommended therapeutic dose legible.
- ☐ The requested dose follows the package's recommended therapeutic dose.
- ☐ If any requested dose differs from the recommended therapeutic dose, written practitioner approval is attached.
- ☐ I will promptly notify the school of changes to my child's medication or health status.

ADDITIONAL INFORMATION

REASON/DIAGNOSIS (optional)	PRACTITIONER NAME/PHONE (if applicable)
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SIGNATURE

PARENT/GUARDIAN SIGNATURE	DATE	AUTHORIZATION EXPIRES
WISCONSIN REQUIREMENTS Wis. Stat. § 118.29(2)(a)1 permits school administration of an over-the-counter drug in accordance with a parent/guardian's written instructions and written consent. A parent-supplied product must be in the original manufacturer's package with ingredients and recommended therapeutic dose legible. Written practitioner approval is required when the requested dose differs from the recommended therapeutic dose. Administration remains subject to the school board's written medication policy under § 118.29(3).		