Howard-Suamico School District<br>Authorization to Administer PRESCRIPTION MEDICATION<br>(Use a separate authorization form for each medication)

Student:
DOB:
School: $\qquad$ Grade: $\qquad$

## FOR COMPLETION BY PHYSICIAN

Reason for medication:
Name of Medication:
Dosage:
Start date of medication:
Stop date of medication: $\qquad$
Administration:
Daily/Scheduled. Time:
As needed: Indication for use:
If needed, how soon can administration of medication be repeated?
Medication cannot be repeated more then:
Side effects when contact should be made with you:
Physician's Name:
Telephone Number:
$\qquad$

I am a licensed healthcare professional authorized to prescribe drugs and have prescribed the above medication to named student.
NOTE: Your signature attests to your willingness and intent to direct, supervise, decide, inspect and oversee the administration of the medication by the non-medically trained designees and that you will accept direct communication from them regarding the administration of the medication. We urge that all instruction be stated in language of the lay person.

Physician Signature:
Fax completed signed form to 920-662-7900 - Pupil Services

## FOR COMPLETION BY PARENT/GUARDIAN FOR PRESCRIPTION MEDICATIONS

A. Parent must deliver the medication to school in its original or prescription container.
B. Parent will notify the school immediately if there is any change in the use of the medication or the prescribed treatment.
C. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

Phone \#1:
Phone \#2:
Parent/Guardian Name (print)

## Parent/Guardian Signature:

## Date:

Parent: Return completed signed form to school office.

