Elcho School District
P.O. Box 800
Elcho, WI 54428
Phone: 715-275-3225 Fax: 715-275-4388

PARENT/GUARDIAN AUTHORIZATION FOR MEDICATION

Student Name: _____ D.O.B: _____

Physician's Name: _____ Date: _____

We are requesting your authority to administer medications(s) during the school day to the above named student.

Medication Name	Dosage	Specific Time	From (Date)	To (Date)

I authorize school personnel to administer the medication(s) outlined above and as prescribed by the physician.

_____ _____
Parent/Guardian Signature Date

I authorize the personnel of the Elcho School District to contact the physician named if the school deems it necessary.

_____ _____
Parent/Guardian Signature Date

Note: The medication must be provided to the school with the following conditions:

5) Child's full name must be on the bottle/container,
6) Name of the drug and dosage must be on the bottle/container,
7) Time to be administered,
8) Physician's name

Please be aware that aspirin and other non-prescribed medication must meet the same criteria as prescription medication. Any medication that does not follow school policy and the above criteria will not be administered during school hours.

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PHYSICIAN'S WRITTEN MEDICATION VERIFICATION

Student Name: _____ D.O.B: _____

Physician's Name: _____ Date: _____

We are requesting your authority to administer medications(s) during the school day to the above named student.

Medication Name	Dosage	Specific Time	From (Date)	To (Date)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Name of Medical Facility: _____

Phone: _____

Please identify below, the specific conditions and circumstances under which contact should be made with the above named student, to the condition or reactions of the student receiving the medications(s).

_____

_____

_____

_____

(Please be specific)

I have reviewed the above material and verify that all information and procedures are correct.

_____ _____

Physician's Signature Date

Note: The medication must be provided to the school with the following conditions:

1) Child's full name must be on the bottle/container,
2) Name of the drug and dosage must be on the bottle/container,
3) Time to be administered,
4) Physician's name

Please be aware that aspirin and other non-prescribed medication must meet the same criteria as prescription medication. Any medication that does not follow school policy and the above criteria will not be administered during school hours.