Green Bay Public School District
Medication Authorization Form

Green Bay Area Public School District
Engagement. Equity. Excellence.

Form is to be used for one medication only. All portions of the medication must be completed before medication can be administered by school district staff. Form needs to be filled out completely or it will be returned and medication will not be given.

Student: _____ Date of Birth: _____

School: _____ Grade: _____ Name of Medication: _____

Dose: _____ Method: (please circle) Oral Inhaled Neb Injectable Topical Eye Ear Other

Give:

- ☐ Daily at the following times: 1. _____ 2. _____ 3. _____
- ☐ As Needed for: _____

Dates to be given: From: _____ to: _____

Parent/Guardian Consent: *Complete for ALL Medication/Procedures at School*

- ► I request and authorize that school staff administer this medication or perform this procedure at school.
- ► I will supply medication in its original, updated, properly labeled container. (An extra bottle can be requested from the pharmacy)
- ► If medications are for a field trip, I will send only the quantity that will be needed during the duration of the trip / camp.
- ► This authorization is for the entire school year unless otherwise indicated.
- ► I will obtain a new physician's order and notify the school in writing for any changes.
- ► I authorize the school nurse to exchange information verbally or in writing with my child's physician regarding this medication/procedure or conditions for which it is prescribed.
- ► I understand that all medication is to be transported to and from school by parent/guardian.
- ► I understand that non-medically licensed school staff will be giving medication, performing procedures, & completing routine medication counts.
- ► I agree to hold the Green Bay Area Public School District, its employees and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication at school.
- ► My signature indicates that I have fully read and understand the above information.

ASTHMA INHALERS: *This student is capable of self-administration and may carry inhaler* **Circle: YES or NO**

EPI PENS ONLY: *Student may self-carry epi-pen.* **Circle: YES or NO**

FIELD TRIPS: ***High school students only:*** *I have reviewed medication dosing and administration directions with my child, and give permission to my child to carry and self-administer this medication un supervised on the field trips (non-controlled substances).* **Circle: YES or NO**

I, the student, agree to take responsibility for the safe storage, management, and self-dispensing of this medication as instructed by my parent and/or physician. I will not share my medications or administer them to any other students. I understand that failure to follow these rules will result in a code violation.

Student signature: _____ ***Date:*** _____

Signature of Parent or Guardian: _____ ***Date:*** _____

Daytime Telephone Number: _____

Physician Authorization: *Required for all over-the counter medications that exceed the recommended packaging dose, all prescription medications, and all herbal or dietary supplements. Required for treatments or procedures needed to be done at school. The above medication is to be administered during the school day. I understand that medication/treatment will be given by non-medically licensed staff that has been trained to do such. Further written instruction will follow from me if the drug is to be discontinued or the dosage or administration time is changed from these instructions.*

ASTHMA INHALERS: This student is capable of self-administration and may carry inhaler: **Circle: YES or NO**

EPI PENS ONLY: Student may self-carry epi-pen. **Circle: YES or NO**

FIELD TRIPS * *I certify that the above named student has been instructed, and may carry and self-administer this prescription medication, supplement on field trips (high school only, no controlled substances).* **Circle: YES or NO**

Symptoms/Side Effects of Medication: _____

Health Care Providers Signature (no stamp): _____ Date: _____

Name of Physician (Printed): _____ NPI Number: _____

Physician Fax Number: _____ Telephone Number: _____