Kewaunee School District

Medication Authorization

To School Personnel:

I, _____, am requesting that _____
(Parent/Guardian) (Name of Student)

Receive prescription drugs as designated below by his/her physician at the time indicated.

I will be responsible for bringing the prescription drugs to school in the container from the pharmacist. I also understand that I am responsible for maintaining a sufficient quantity of the medication at the school to avoid any interruptions in the physician's orders. Failure to do this will result in the termination of the school's administered medication program.

I hereby give permission to the school to give the medication to my child according to the directions stated below. I agree to hold the School District of Kewaunee, 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.

I agree to notify the school in writing at the termination of this request or when any change in the medication order is necessary.

I understand that if my child refuses the prescription drugs, force will not be exerted to make him/her comply.

Name of Medication (Generic & Trade)	Dosage (MG/ML)	Time (A.M./P.M.)	Possible Side Effects

The above orders shall be effective through _____, unless discontinued or changed by me with request in writing.

_____ _____ _____
(Parent Signature) (Date) (Address/Phone)

_____ _____ _____
(Physician Signature) (Date) (Address/Phone)

[] I give permission for the KSD school nurse to send my child home with their medications on the last day of school or when the medication is discontinued.