IOWA-GRANT ELEM/MIDDLE SCHOOL PARENT/GUARDIAN
MEDICATION AUTHORIZATION FORM
2017-2018 SCHOOL YEAR

Over the Counter Medications – As Needed Medications
(This form only needs to be filled out if the school is administering over-the-counter medication to a student during school hours.)

Student's Name: _____ Date of birth: _____

Address: _____ Grade: _____

As the parent/guardian of the above mentioned student, I give the Iowa-Grant Elem/Middle School Permission to administer the following medication(s) to my child for the following reason or diagnosis:

_____

_____.

All medications must be furnished by the parent and are to be in the original bottle. Do not send medication in baggies or envelopes as they will not be accepted by office staff.

Medication/Dosage (mg, cc, ml, etc)	How it is to be given	How Often (specific)	Start Date	Stop Date	Considerations/ Side Effects
1.					
2.					
3.					

As the parent or guardian of the above mentioned student, I will keep the school district aware of any changes in medication(s) profile or health concern of my child.

As a part of the Wisconsin Statute Chapter 118.29, Administration of Drug to Pupils and Emergency Care, school districts are required to have permission from a medical provider and parent to administrator medications at school. As part of this authorization form, school district employees may contact the medical provider with questions regarding the medication administration including clarification regarding dosage, side effects or indication of the medication(s) listed above with parent permission.

Parent(s)/Guardian(s) Signature: _____ Date: _____