# School District of Grafton

*Preparing Learners for a Dynamic Tomorrow. Every Student. Every Day.*

## Authorization to Dispense Prescription / Non-Prescription Medication(s)

☐ Kennedy Elementary School
Phone: (262) 376-5650
Fax: (262) 376-5660

☐ Woodview Elementary School
Phone: (262) 376-5750
Fax: (262) 376-5760

☐ John Long Middle School
Phone: (262) 376-5800
Fax: (262) 376-5810

☐ Grafton High School
Phone: (262) 376-5500
Fax: (262) 376-5510

Student Name: _____ Grade: _____ Birthdate: _____ Date:_____

***Important Guidelines:***

***Physician Signature is required*** *for: all prescription medications; any over-the-counter medication above the manufacturer's recommendations.* A signed **Emergency Care Plan** form must accompany this authorization for prescribed epinephrine auto-injector, rescue inhaler, anti-seizure medication, anti-diabetic medication, and/or Glucagon.

Herbal, vitamin or nutrition supplements, and any medications administered regularly at school for longer than ten days also require a physician signature.

All medication must be presented to school in original packaging. Prescription label must match instructions from prescriber. Medication may not be expired. New forms and medication must be provided each year. New forms must be provided for any changes.

| Name of Medication | *OTC or Rx? | Dosage (amount) | Time | Route (oral, etc.) | Reason | Start Date | Stop Date |
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**Please write "OTC" for over-the-counter or "Rx" for prescription medication.*

### PARENT / GUARDIAN AUTHORIZATION FOR MEDICATION(S) LISTED ABOVE

*I give consent for designated school personnel to administer the above listed medication/s as indicated during the school day. I agree to hold the Grafton School District and its employees harmless in any and all claims arising from the administration of this/these medication(s) at school. I agree to notify the school in writing at the termination of this authorization or when any changes in the above order are necessary. I understand that school staff may contact me with any concerns regarding medication administration. I give permission for the school's designated health care professionals to contact my child's physician with any concerns regarding medication administration. I understand that I, the parent, must pick up any unused medications at the end of the school year or the medication will be discarded.*

_____ _____ _____/_____/_____

Signature of Parent/Guardian | Phone Number | Date

### PHYSICIAN AUTHORIZATION FOR PRESCRIPTION MEDICATION(S)

**Note:** Before medication(s) prescribed by a physician can be administered by school personnel, a signed statement from the physician must be on file and must include (a) the conditions and circumstances for administering the medication(s), (b) the prescribed dosage, and (c) the frequency of administration. The medication instructions above may be used for this purpose. In addition:

- Prescribed medication(s) are to be administered to this student who has a diagnosis of_____.
- In the event that the medication administration is missed by more than one hour, I instruct the following:

_____

- Additional instructions/comments:

_____ _____/_____/_____

Signature of Physician or other Healthcare Provider with Prescriptive Rights | Date

Print Physician Name: _____ Physician's Phone: _____

Rev 05/2018 District Nurse Signature of Review:_____ Date: _____ Entered ☐