School District of Webster ▪ P.O. Box 9 ▪ Webster, Wisconsin 54893
www.webster.k12.wi.us

Authorization to Administer Medication at School

Name of Student_____ Date of Birth:_____
Grade/Teacher_____
Clinic:_____
Physician's Name:_____

INSTRUCTIONS FOR PERSCRIPTION MEDICATION TO BE FILLED OUT BY PHYSICIAN

In my opinion, it is necessary to administer this medication during the school day.
Medication:_____ Dosage:_____
Time to be Given:_____ Route:_____
Duration to be Given:_____
Purpose of Medication:_____

Date:_____ Physician's Signature:_____

INSTRUCTIONS FOR NON-PRESCRIPTION MEDICATION TO BE FILLED OUT BY PARENT/GUARDIAN

Medication:_____ Dosage:_____
Time to be Given:_____ Route:_____
Purpose of Medication:_____

I hereby give permission for _____ to take the above medicine at school as ordered. I understand that it is my responsibility to furnish this medication and I will personally bring it to school in its original, labeled container (instructions/dosage must match physician's order). If the prescription is changed, a new form for parent consent and a new physician's order must be completed before school staff can administer the medication. I authorize the exchange of information regarding these medicines between my child's clinic and school for the duration of the school year.

Date:_____ Signature Parent/Guardian:_____

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