Port Edwards Public Schools

801 Second Street, Port Edwards, W 54469-1301
715-887-000
Elementary School FAX: 715-887-9095
John Edwards Middle & High Schools FAX: 715487-9040

www.pesd.com

AUTHORIZATION TO ADMINISTER NON-PRESCRIPTION MEDICATION
or
SHORT-TERM PRESCRIPTION MEDICATION

Name of Student: _____ Date of Birth: _____

School: _____ Grade/Teacher: _____

Name(s) of Parent(s)/Guardian(s): _____

Phone: (Home) _____ (Work) _____

I give permission for my son/daughter to receive the following medication:

Name of Medication: _____
(Generic and Trade Names)

Dosage (amount to be given): _____
(Physician signature required if dosage exceeds manufacturer's recommendation)

Form (circle one): Tablet Capsule Liquid Inhaled
Eye/Ear/Nose Drops Ointment

Time (a.m./p.m.): _____

Reason: _____

Date to start: _____ Date to end: _____

I will be responsible for:

1) delivery of the medication in the **original container/packaging or the pharmacy-labeled container** to the school office
2) maintaining a sufficient supply of medication
3) keeping school personnel informed of changes in the medication (dosage, time)
4) completing a new form for any changes in the medication
5) picking up any unused medication

I hereby release the Board of Education and its agents and employees from any and all liability that may result from my child taking, this medication.

_____ _____
(Parent/Guardian Signature) *(Date)*