Princeton School District

Prescription/Over-the-Counter Medication Form

All portions of this form must be completed before medication can be administered by school district personnel. Incomplete forms may result in the form being returned for full completion.

Keep in mind:

- All prescription medication requires BOTH a practitioner signature and a parent/guardian signature;
- All over-the-counter medication requires ONLY parent/guardian signature, unless outside of the recommendations of manufacturer, in which case a practitioner signature is also required.
- All medication must be brought in original pharmacy/manufacturer labeled container by parent/guardian. **We will not administer medication without this.**

Student:	Grade:	Date of Birth:
Name of medication:	Dosage:	Time(s) given:
How administered (oral, injection, inhaler, topical, other):		Stop date:
Reason for medication:		
Explain possible side effects or other special instructions:		
Practitioner's Name:	Clinic/Hospital:	Phone:

I hereby give permission for Princeton School District personnel to administer the medication/treatment(s) **I have provided** for my child, according to the directions stated and authorize them to contact the practitioner if there is a question. I further authorize the practitioner to render treatment to my child, as appropriate and necessary, arising out of administration of the medication. Authorization is hereby granted to release information to appropriate school district personnel and classroom teachers. **Parent signature consents for communication between school personnel and physician regarding this medication and any concerns arising from such. I agree to hold the Princeton School District, its employees or agents who are acting on this authorization, harmless in any and all claims arising from the administration of this medication at school. I also agree to inform the school immediately and in writing of any change or discontinuation of this order.** I shall pick up any unused portions of the medication/treatment within 3 business days of completion of the school year or when this order has been discontinued. *I acknowledge that the medication/treatment supplies will be destroyed if it has not been picked up after 5 business days.*

Parent/guardian name (please print legibly):	Date:
Parent/guardian signature:	

PARENT & PRACTITIONER AUTHORIZATION

The practitioner whose signature follows hereby authorizes Princeton School District personnel to administer medication as prescribed and also agrees to accept communication regarding the administration procedures. It is understood that the medication will be given by non-licensed, but specially trained personnel, and *the reason(s) that the medication must be given during the school day should be given.*

☐ **Checking this box indicates the medication may be carried by the student per section 118.291 & 118.292 (Wisc. Stats.), and the student has demonstrated proper use of medication (applies ONLY to rescue inhalers & Epinephrine auto-injectors).**

Medical rationale for medication to be given during the school day:	
Practitioner signature:	Date:
Parent/guardian signature:	Date:

Medication Dispense Log

Date	Time	By Whom	Notes / Comments