

**LAKE MILLS SCHOOL DISTRICT  
AUTHORIZATION FOR ADMINISTRATION OF  
PRESCRIPTION AND NON-PRESCRIPTION MEDICATION**

Student's Name \_\_\_\_\_ Physician's Name \_\_\_\_\_  
Birthdate \_\_\_\_\_ Physician's Address \_\_\_\_\_  
School \_\_\_\_\_ Grade/Teacher \_\_\_\_\_  
Parent/Guardian \_\_\_\_\_ Physician's Phone \_\_\_\_\_  
Phone \_\_\_\_\_ Physician's FAX \_\_\_\_\_

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**TO THE PHYSICIAN/PARENT:** According to the State of WI Medical Examining Board and the Lake Mills School District po5330 Administration of Medication/Emergency Care, it is required to fill out this form before school personnel may dispense or administer medication. Medication must be supplied in the original container or packaging. For safety and liability reason, medication received in any container other than the original will not be acceptable for staff administration. Parent/Guardian: By signing this form, releases the Board of Education, its agents and employees from any and all liability that may result from taking this medication and you agree to provide safe transportation of medication to and from school.

Medication \_\_\_\_\_ Reason for this Medication \_\_\_\_\_

Amount and time to be given \_\_\_\_\_

Duration of treatment (start date/stop date) \_\_\_\_\_

If given on an "as needed" basis, please describe \_\_\_\_\_

How soon can it be repeated? \_\_\_\_\_

Side effects and/or special instructions \_\_\_\_\_

***Self-Administration of Medication by Student:*** It is strongly recommended that all medications be administered by designated school staff and be kept secure in the school office for those students in Pre-K-8. If a student in grades Pre-K-12 needs to carry and self-administer certain emergency medications such as epipen, asthma inhaler, insulin or glucagon, special permission will be granted with the parent and physician authorization.

Please specify if student may carry and self-administer this medication (Specify type above): \_\_\_\_\_ YES \_\_\_\_\_ NO

I, the prescribing physician, am willing to accept direct communication from the person dispensing and administering the above medication.

PHYSICIAN'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
(Required for Prescription and Non-Prescription medications).

