Winside Public School
203 Crawford
Winside, NE 68790
High School **(402) 286-4465** **Fax: (402) 286-4588**
Elementary **(402) 286-4466** **Fax: (402) 286-4582**

AUTHORIZATION FOR ADMINSTRATION OF MEDICATION AT SCHOOL

STUDENT'S NAME: _____ GRADE: _____

DATE MEDICATION TO START: _____ END: _____

NAME OF MEDICATION: _____

STRENGTH OF MEDICATION: _____
(milligrams, micrograms, etc.)

DOSE TO BE GIVEN: _____
(# of capsules, tablets, drops, teaspoons, etc.)

TIME MEDICATION TO BE GIVEN: _____

REASON FOR MEDICATION: _____

I request/authorize the school to give medications to my student in accordance with the health care provider and or my instructions written above. I understand that unlicensed staff may be assigned to provide medication to my student, and I accept ultimate responsibility for monitoring the effects of this medication.

PARENT/GUARDIAN SIGNATURE: _____ Date: _____

If this is a prescribed medication the label on the container you send to school must match your instructions above. (You can ask your pharmacist to dispense medication in two bottles, one for home, and one for school.)

If this is an over the counter, (non-prescription medication) this also must be in the original container or package, including cough drops, creams or lotions.

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FOR OFFICE USE

Date medication received: _____ count if necessary: _____

School nurse signature: _____