The School District of Sturgeon Bay
Medication Authorization Form 2025/26

_____

Student First & Last Name Date of Birth Grade

***NOTE: Any change in medication will require a new authorization form.**
If it is a prescription medication the form MUST be signed by the provider before it can be administered at school.

Prescription Medication

1. _____
   Name of Medication Dosage Instructions/Time Reason
2. _____
   Name of Medication Dosage Instructions/Time Reason

Current school year _____ yes _____ no If no, dates: _____ to _____

_____ _____ _____
Physician/Provider Name Physician/Provider Signature Date

I hereby give permission for the school nurse or designated school staff to give the above medication to my child according to the directions stated. I also authorize school personnel designated in medication administration to contact my child's practitioner or me if there is a question regarding medication. I agree to notify the school when the drug is to be discontinued and/or the dosage or time changed. I agree to hold the District, its employees and agents, who are acting within the scope of their duties, harmless in any and all claims arising from the administration of this medication at school.

_____ _____ _____
Parent/Guardian Name Parent/Guardian Signature Date

Non-Prescription Medication

1. _____
   Name of Medication Dosage Instructions/Time Reason
2. _____
   Name of Medication Dosage Instructions/Time Reason

Current school year _____ yes _____ no If no, dates:_____ to _____

I hereby give permission for the school nurse or designated school staff to give the above medication to my child according to the directions stated. I also authorize school personnel designated in medication administration to contact my child's practitioner or me if there is a question regarding medication. I agree to notify the school when the drug is to be discontinued and/or the dosage or time changed. I agree to hold the District, its employees and agents, who are acting within the scope of their duties, harmless in any and all claims arising from the administration of this medication at school.

_____ _____ _____
Parent/Guardian Name Parent/Guardian Signature Date

Request To Carry Medication

***Students will ONLY be allowed to carry <u>EMERGENCY MEDICATIONS (Inhaler, EpiPen, Seizure, Glucagon)</u>**

I request that my child be allowed to carry his/her medication (as written above) and be responsible for its proper storage and use. I will support my child to follow the below agreement & if s/he does not, I will be contacted to discuss an alternative plan. I understand the medication must be in the original packaging and kept in a secure location.

Parent/Guardian Signature: _____Date: _____

I am able to demonstrate correct use/administration of my medication (as written above). I agree to not misuse my medication in any way. I will not share my medication with another student. I am aware of the possible side effects that may occur while taking the above medication and agree that I will report to the office if any side effects may occur. I am aware that if I do not follow the above agreement my parent/guardian will be contacted to discuss an alternative plan.

Student Signature _____Date: _____