Health and Nursing Services
1701 E Capitol Drive
Shorewood, WI 53211

Dispensing Prescription/Non-Prescription Medication

Student Name:_____ Date of Birth:_____

Medication	Reason Needed	Dosage	Route	Frequency

- Parents must complete this form for all medication. No medication will be administered without **written** consent.
- Forms listing prescription medication must be signed by a licensed prescriber.
- Medications must be sent in the **original package**. Prescription label match instructions from the prescriber.
- New forms and medication must be provided every year. Medications are not stored anywhere in the district over the summer. All medication not picked up by June 13, 2025 will be disposed of.
- New forms must be provided if there is a change to the medication. (ie: dose, time it's given, etc)
- Parents must supply all medication for elementary students. Ibuprofen & Acetaminophen swallowable tablets are supplied at SIS and SHS, however it will not be administered to students without Infinite Campus OLR electronic authorization or written authorization from parent/guardian. **Email or verbal authorization will not be accepted.**

I hereby release Shorewood School District and its employees from any and all liability that may result from my child taking the above medication(s). I will be responsible for bringing the prescription medication to school in a labeled container from the pharmacist. I also understand that I am responsible for maintaining a sufficient quantity of the medication or supplies at the school. Failure to do this will result in an interruption of the physician's order or discontinuation of the school's administration of the medication/procedure for my child. I understand that, if my child refuses to take the prescribed medication(s) or allow the procedure(s), force will not be used by school personnel to make my child comply. School personnel have permission to communicate with the prescribing medical provider regarding use, side effects, response, and contraindications of the medication(s) or the procedure results or frequency. I can rescind my permission at any time. Additionally, I understand and agree with the information stated above.

Parent/Guardian Signature:_____ Date:_____
Phone Number:_____ Emergency Contact: _____

The student listed above has one or more of the following **emergency/rescue medications**: *(Please circle)*

Asthma Inhaler **Epi-pen** **Glucagon Injection** **Insulin**

The student may self-carry their **emergency** medication: (**Initial for Yes**) _____
The student may self-administer their **emergency** medication: (**Initial for Yes**) _____

NO OTHER MEDICATION MAY BE SELF-CARRIED OR SELF-ADMINISTERED BY STUDENTS

Prescription Medication Physician Authorization

_____
Physician name Phone # Fax #

_____
Address

_____
City/State/ZIP

_____
Physician's signature Date

Any additional information/special accommodations regarding the medication listed:
_____