Authorization Form for Administering Medication to Students

- No medication will be given at school until this form is **fully completed**.
- **The medication must be given to the office in an original pharmacy or manufacturer container, labeled with the student's full name**.

Student Name:______________________________ Grade:_______
Siblings who can also share OTC medication:________________________________

Medication:________________________ € ***Prescription*(see below)** € Over the counter
(Please list additional medications on the back of this form)

Reason/circumstances for giving:____

Route: € Tablet/capsule € Liquid € Inhalation € Topical € Drops € Injection

Dosage:______________________________ Time(s)/Frequency:______________________
Any increase or decrease of the dosage** (for either prescription or over the counter medicine) **other than what is indicated on the medication label must be authorized by the physician.

€ To be administered temporarily. Date to begin:____________ Date to end:_____________
€ To be administered on an ongoing or "as needed" basis.

FOR ALL PRESCRIPTION MEDICATIONS

Prescribing Physician – SIGNATURE REQUIRED
For all prescription medication or dosage changes for non-prescription medication:
I authorize Eastbrook Academy to administer medication as prescribed to the student whose name appears on this form and I also agree to accept communication regarding the administration procedures (if needed).

If medication is to be self-administered, is the student able to do this unassisted? **YES / NO**

***Signature of Prescribing Physician**______________________________ Date:__________

School personnel have my permission to administer this medication as indicated above. I release Eastbrook Academy and its employees from all liability which may result from acting on this request. It is understood that the medication will be given by specially trained personnel only. I also agree to inform the school in writing of any change or discontinuation of this order. I understand that the medication will be destroyed if it has not been picked up after 10 days.

Signature of Parent / Guardian________________________________ Date:__________

eastbrookacademy.org

5375 North Green Bay Ave
Milwaukee, WI 53209
414-228-7905

Another Medication:______________________________________

€ ***Prescription*** (A doctor must sign on the front of this form) € Over the counter

Reason/circumstances for giving:____

Route: € Tablet/capsule € Liquid € Inhalation € Topical € Drops € Injection

Dosage:_____________________________ Time(s)/Frequency:____________________

Any increase or decrease of the dosage** (for either prescription or over the counter medicine) **other than what is indicated on the medication label must be authorized by the physician.

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