

**SWALLOW SCHOOL 2009-2010 MEDICATION  
ADMINISTRATION AUTHORIZATION FORM**

This form pertains to Physician/Practitioner prescribed medication **and** over-the-counter medications.

**Box 1 – Practitioner Prescribed Medication** - your Practitioner needs to fill out the top portion (student’s name, DOB, etc.) and the info in Box 1, “Practitioner Prescribed Medication”, with any prescribed medications that may be administered during the school day/activities. He/She needs to sign and date the bottom in the Prescribed Medication Section. (Please note – allergy/EPI pen and Diabetic/INSULIN is a separate form).

**Box 2 – Over the Counter/As Needed Medication** – parents need to fill out the top portion (student’s name, DOB, etc.) and the information in Box 2 for administration of all over-the-counter medications. Remember to include **all** of the information: Route (oral, inhalation, topical, etc.), Dose ( \_? \_mg), Frequency (as needed, every 4-6 hours, etc.), Duration (ie: 1/1/09-1/7/09, or, 2009-10, indicate dates). If it is not filled out completely, meds cannot be given (according to WI state statutes). Keep this form on hand in case medication needs to be given any time during the school year, and send it in with the medication. (Forms can also be found on the school website.) Parents need to sign the form if **any** of this section is filled out, acknowledging accuracy and releasing Swallow School from any liability, and give consent for school to contact Practitioner if need arises. One form needs to be filled out for **each** student at Swallow School.

**Please administer the following medication(s) to:**

Name of Student	DOB	Ht	Wt
Diagnosis(s)	Allergies		

**BOX 1 - PRACTITIONER PRESCRIBED MEDICATION:**

Please check box if student may self carry inhaler.

Medicine	Route	Dose	Frequency	Duration	Direct contact shall be made with MD/NP should the student receiving the medication develop any of the following conditions or reactions to the medication (if none, so state)
				From: To:	
				From: To:	
				From: To:	

Hospital/Clinic/Office	Phone Number:
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Address Street, City, State, Zip

<b>Physician’s Signature</b> (required for MD/NP prescribed medicine)	<b>Date:</b>
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**BOX 2 - OVER-THE COUNTER/AS NEEDED MEDICATION:**

Medicine	Route	Dose	Frequency	Duration	Condition under which medication should be given (i.e. pain, cough)
				From: To:	
				From: To:	
				From: To:	

<b>Parent’s Signature</b>	<b>Date</b>
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Additional Information/Instructions

