School District of New Berlin
Parent Authorization – Non-Prescription Medication

Full Name of Child _____Date _____

School_____ Grade _____

Name of Drug _____ Dosage _____

If medication dose is determined by the child's weight, indicate child's weight in pounds_____

Hour it is to be given _____

Reason for medication _____

I shall supply a properly labeled bottle of medication in its original packaging**. I understand that the instructions for administration may not exceed the manufacturers' recommended dosages. The medication MUST be stored and taken in the health room or school office.**

Expired medication will not be administered to the student. It is the parent's responsibility to replace medication before it expires.

I hereby give my permission to the designated school personnel, appointed by the principal, to give the medication to my child according to the directions stated above and further authorize them to contact the child's physician if warranted.

I further agree to hold the School District of New Berlin and the designated personnel harmless in any and all claims arising from the administration of this medication.

Self-administration of non-prescription medication is not permitted.

I agree to notify the school in writing at the termination of this request or when any change in the above orders is necessary.

Written authorization for medications expire at the end of the school year, if not discontinued during the course of the school year. **Medication must be picked up by a parent at the end of the school year or the medication will be disposed of**.
New orders need to be obtained for all medications at the beginning of each school year

_____ Date _____
Signature of Parent/Legal Guardian