Bangor School District

P.O. Box 99 · 700 10th Ave S. · Bangor, WI 54614
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2023–2024 School Medication and Procedure Authorization Form

Student Name: _____ Grade: _____ Birth Date: _____

Allergies: _____ Weight (Elementary Only): _____

NON-PRESCRIPTION MEDICATIONS

Please initial next to the medications and sign/date the bottom giving permission for the school district staff to administer as needed per the package recommendations for the current school year:

_____ **Acetaminophen (Tylenol)** for fever or pain relief
_____ **Ibuprofen (Motrin/Advil)** for fever or pain relief
_____ **Diphenhydramine (Benadryl)** for hives and/or allergic reactions
_____ **Calcium Carbonate (TUMS)** for upset stomach or indigestion
_____ **Cough Drops** for cough or sore throat (limited to two per day)
_____ **Antibiotic Ointment** for scrapes or cuts
_____ **Hydrocortisone 1% Cream** for itching, rash or insect bite
_____ **Vaseline, unscented lotion, and/or chap stick** for dry, chapped skin/lips
_____ **Other Non-Prescription medication:** Initial here, provide medication, fill out next section except for Practitioner's signature

PRESCRIPTION MEDICATIONS AND OTHER MEDICATIONS OR PROCEDURES

Medication/Procedure: _____ Dosage: _____

Time/Frequency: _____ Effective Date: _____

Reason for medication: _____

Contact for following symptoms: _____

Student may carry inhaler at school: **YES NO** Student may carry EPI-Pen in school: **YES NO**

The above prescription medication or procedure will need to be administered at school:

Practitioner's Signature: _____

PARENT/LEGAL GUARDIAN CONSENT

I hereby give permission for school personnel to administer the above medication(s) from the nurse's stock to my child according to practitioner's orders, my instructions and/or package recommendations. I authorize the school to contact the practitioner verbally or in writing with any question or concern. I release the school from any liability claims as a result of the administration of this medication or procedure as directed. Staff will contact parent/guardian if non-scheduled medications are given to ensure no duplicate medications are administered if needed. Some medications will not always be available. If your child needs frequent doses please send own supply.

Parent/Guardian Signature: _____ Date: _____

**Complete with signature and date. Return to the school office or nurse's office.*

Medication Administration Record

Students Name: ________________________________ **Date of Birth**: _____________ **Grade**: ________

Medication, Dosage, Time:

Dates: **August 28, 2023 – May 23, 2024**

Date	Time	Initials	Observations	Date	Time	Initials	Observations

Initials	Signature	Initials	Signature

****To be filed in Student Health Folder When Medication is Discontinued**