City of Waukesha Parks, Recreation & Forestry

Authorization to Administer Prescribed or Over the Counter Medication

2019-2020

To be completed and return only if child is taking medication while in a WPRF Cool School program.

Child's Name:_____ **Date of Birth:** _____

Address:_____ **City:**_____ **Zip:**_____

Program Site:_____ **Parent/Guardian:**_____

Home Phone:_____ **Work Phone:** _____ **Cell Phone:** _____

Prescribed Medication Only - PHYSICIAN ORDER

Name of Medication	Dosage	Form of Administration	Time	Possible Adverse Side Effects

Physician's Name:_____ Phone Number: _____

Physician's Signature:_____ Date:_____

Over the Counter Medication – Parent Order

Name of Medication	Dosage	Form of Administration	Time	Possible Adverse Side Effects

I give permission for my son/daughter to receive the medication authorized by his/her physician. I give permission to share this information with the appropriate WPRF staff. I will:

- Deliver medication to Staff in pharmacy-labeled container (Prescription only) or original container/packaging (over the counter only).
- Maintain a sufficient supply of medication at site daily.
- Obtain a new authorization form if any changes occur with this medication.
- Pick up any un-used medication.

The above order shall remain in effect through the end of the program for the 2019-2020 school year unless discontinued, changed by the physician, or if the parent/guardian withdraws the request in writing.

_____ _____

Parent/Guardian's Signature *Date*