



**City of Waukesha Parks, Recreation & Forestry**  
**Authorization to Administer Prescribed or Over the Counter Medication**

**2020-2021**

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**

<b>Name of Medication</b>	<b>Dosage</b>	<b>Form of Administration</b>	<b>Time</b>	<b>Possible Adverse Side Effects</b>

**Physician's Name:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_  
**Physician's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Over the Counter Medication – Parent Order**

<b>Name of Medication</b>	<b>Dosage</b>	<b>Form of Administration</b>	<b>Time</b>	<b>Possible Adverse Side Effects</b>

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 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 2020-2021 school year unless discontinued, changed by the physician, or if the parent/guardian withdraws the request in writing.*

\_\_\_\_\_  
*Parent/Guardian's Signature*

\_\_\_\_\_  
*Date*