



Health Department

729 Clay Street
Darlington, WI 53530
P. 608-776-4895
F. 608-776-4885

MEDICATION ADMINISTRATION CONSENT FORM: Prescriptions

Student Name: _____ Grade/Teacher: _____

Birth Date: _____ Allergies: _____

NOTE TO PARENTS/GUARDIANS

The School District **REQUIRES** that students who need prescription medication during school hours **MUST** do the following:

1. Present a written consent form filled out and signed by the parent and **PHYSICIAN**. (Form below. If form is unavailable, a prescription pad form signed by the physician may be used.)
2. Bring the prescription medication in the original prescription container, properly labeled by a Pharmacist.

CONSENT FOR MEDICATION PRESCRIBED BY A PHYSICIAN

Medication: _____ Dosage: _____

Time to be given: _____

If needed, how often can administration of medicine be repeated? _____

Reason for Medication to be given: _____

Precautions: _____

If the medication is an inhaler, please answer the following questions:

Where is the inhaler to be stored?

- ☐ in designated area (health room, nurse's office)
- ☐ in student's possession
- ☐ in designated area & in student's possession (be sure to send 2 inhalers)

() I have instructed _____ in the proper way to use his/her inhaled asthma medications. It is my professional opinion that he/she should be allowed to carry and use this inhaled medication by him/herself.

() It is my professional opinion that _____ should not carry and use his/her inhaler asthma medication by him/herself.

Physician Signature/Phone _____ Date: _____

Parent Signature/Phone _____ Date _____





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MEDICATION ADMINISTRATION CONSENT FORM: Over the Counters

Student Name: _____ Grade/Teacher: _____

Birth Date: _____ Allergies: _____

NOTE TO PARENTS/GUARDIANS

The School District **REQUIRES** that students who need over-the-counter medication during school hours **MUST** do the following:

1. Present a written consent form filled out and signed by the parent or legal guardian. (Consent form below)
2. Bring over-the-counter medication in the original container. Do not send medication in plastic baggies, envelopes, or other unmarked containers.

NOTE: Many of the short-term medications do not need to be given at school. For example medication taken 3 times per day can be given in the morning before school, right after school, and at bedtime.

CONSENT FOR MEDICATION OVER-THE-COUNTER MEDICATION

Medication: _____ Dosage: _____

Time to be given: _____

Reason for Medication to be given: _____

By signing below, I give school personnel permission to administer the above indicated non-prescription medication to my son/daughter. I understand that all medication should be in their original container. I give permission that necessary information related to my child's condition be shared with the school nurse

Parent Signature

Date

