WOODS ELEMENTARY SCHOOL

N2575 SNAKE ROAD
LAKE GENEVA, WI 53147
(262)248-3816
FAX (262)248-7021

NON-PRESCRIPTION
(OVER THE COUNTER)
MEDICATION ADMINISTRATION CONSENT FORM

(Please print clearly)

Student Name: _____ DOB: _____

Practitioner Name: _____ Phone: _____

Name of medication & strength (e.g. mg.):

Time to be administrated: _____

Dosage:

_____

Reason for medication: _____

Duration: From _____ to _____

I hereby give my permission to Woods School to administer medication to my child according to the directions stated above and further authorize them to contact the child's practitioner if warranted (should the need arise for the safety of my child and other students). I agree to hold Woods School, its employees and agents who are acting in good faith and within the scope of their duties harmless from any and all claims arising from the administration of this medication at school.

I will notify the school in writing whenever this consent is withdrawn prior to the end of the duration period stated above.

_____ _____

Signature of Parent/Legal Guardian Date

Note: Person(s) who will be administering medication during school hours are listed in the principal's office. Before a medication will be administered by the school or agent thereof, this form shall be completed and returned to the school principal who shall file and retain the same. A copy must also be kept in the nurse's office. Medications must be in their original containers with the following Information printed on the container: 1) Student's full name; 2) Medication name and dosage/time to be given.

_____ _____

Practitioner's Signature Date