SCHOOL DISTRICT OF SLINGER MEDICATION CONSENT FORM

Wisconsin State Statute 118.29 and Slinger School District policy states that NO medication (prescription or non-prescription) will be administered by school personnel unless and until a medication consent form is completed and returned to the school. A complete medication consent includes: written parental authorization to administer medication in school and written instructions from a licensed health care professional for prescription medication.

To be completed by parent/guardian (for all prescription and/or all non-prescription medication)

STUDENT ____________________________ DATE OF BIRTH ____________________________
GRADE ________ TEACHER ____________________________
NAME OF MEDICATION ____________________________ DOSAGE ____________________________
TIME TO BE GIVEN __________________ STORAGOREQUIREMENTS □ none □ refrigerate
FORM OF MEDICATION: (check one please)

□ Tablet/Capsule  □ Liquid  □ Inhaler  □ Other ____________________________
START: □ date form received □ other date: ____________________________
STOP: □ end of school year □ other date/duration: ____________________________
Keep medication in school □  Send home every night □  Other □ ____________________________
Reason for Medication: ________________________________________________________________________________________
Possible Side Effects: __________________________________________________________________________________________
□ I hereby give my permission to the above designated person(s) to give the medication to my child according to the directions stated below.
□ I further give my permission to the school authorities to contact the child’s physician, if necessary.
□ I agree to notify the school in writing at the termination of this request or when any change in the order(s) is necessary.

All non-prescription medication is to be sent to school in the original package/container with the name of medication, dosage, etc. on label and students name written on the container.

(Signature of Parent) ______________________ (Date) ______________________
Home Phone ______________________ Work Phone and Ext. ______________________ Other ______________________

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To be completed by physician (for prescription medication only)

(student) should receive medication at school as indicated on the prescription. I agree to be available for direct communication from the person(s) dispensing or administering the medication. Specific conditions under which I should be contacted regarding the condition or reactions of the student receiving the medication are:

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All prescription medication is to be sent to school in a proper pharmacy labeled bottle, giving full name, name of Medication, dosage, time to be given, physician, and expiration date.

Return to: YOUR CHILD’S BUILDING SECRETARY

Physician’s Signature ______________________
Office/Clinic ______________________
Phone ______________________
Fax ______________________