# Appleton Area School District

P.O. Box 2019, 120 E. Harris St., Appleton, WI 54912-2019 920-832-6161
*Student Services 920-997-1399, ext. 2106*

***Note: Return the completed form to the parent or the student's school of attendance.***

*School FAX #:* ______________________________

## HEALTH SERVICES
## ADMINISTRATION OF MEDICATION CONSENT

***Physician Statement****

*One form for each medication given at school*

Student Name:__________________________________ DOB:____________________

School of Attendance:____________________________ Grade/Room:______________

Medication Name**/Strength:____________________________________________

Dosage:**__________________Route:**_______________Frequency:_____________
(in mg, ml, etc.)

Starting Date:__________________Termination Date:__________________________

Reason for Medication:_____________________________________________________

Precautions, possible untoward reactions, and/or interventions:_________________

________________________________________________________________________

Prescribing physician name:_________________________________________________
(please print)

Phone:____________________________ FAX:_____________________________

Address:___________________________________________________________

________________________________________ ____________________
(Signature of Physician) (Date)

*Form to be **completed by R.N. or M.D. and signed by M.D**. – one medication per form
**A new physician statement will be needed for any changes in medication, dosage, route, or frequency.

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**HEALTH SERVICES**
**ADMINISTRATION OF MEDICATION CONSENT**

***Parent/Guardian Statement***

*Use one form for each medication*

Student Name:________________________________________ DOB:________________________

School of Attendance:___________________________________ Grade/Room:__________________

Medication Name:______________________________ Prescribed*_______ Non-Prescribed_______

Dosage:________________________How Given:____________Time to be Given::________________
(in mg, ml, etc.)

Starting Date:_____________________________ Ending Date:_________________________________

Reason for Medication:____________________________________________________________

If "as necessary", conditions under which medications should be given:____________________________

Precautions, possible untoward reactions, and/or interventions:__________________________________

Prescribing physician name:_________________________________________ Phone:_____________
(please print)

I hereby give my permission to school personnel to give this medication to my child according to the directions stated above and to contact the child's physician if necessary.

I further agree to hold the Appleton Area School District and above person harmless in any and all claims arising from the administration of this medication at school.

I agree to notify the school in writing when any change in the above order is necessary.

______________________________________________ ____________________________
(Signature of Parent) (Date)

Home Phone:__________________________________ Work Phone:___________________________

***A physician written, signed statement and a pharmacy labeled container with accurate dosage and administration instruction must be supplied by the parent/guardian.**

I agree to allow my child to transport the medication container (filled or empty) to and from school for the purpose of maintaining medication needed at school for administration.

YES________ NO_________

HS-018
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