



# Appleton Area School District

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

920-832-6161

**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: \_\_\_\_\_

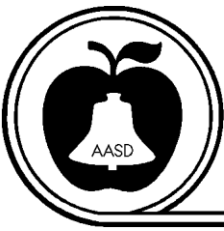
Address: \_\_\_\_\_

\_\_\_\_\_  
(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 \_\_\_\_\_