

Friess Lake School District

1750 Hwy 164
Hubertus, WI 53033

Phone: 262 628-2380
Fax: 262 628-2546

Administration of Medication Consent

A separate form is needed for each medication.

Student Name: _____ **Grade:** _____ **D.O.B** _____

Medication Name: _____ **Prescription** **Non-Prescription**

Dosage: _____ **Time:** _____

Starting Date: _____ **Termination Date:** _____

Reason for Medication: _____

If "as necessary," conditions under which medication should be given: _____

Precautions, possible unfavorable reactions, and/or interventions: _____

Prescribing Physician Name (please print): _____ **Phone:** _____

Fax: _____

Physician Signature: _____

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

A physician's written, signed statement and pharmacy-labeled container must be supplied by the parent/guardian if prescribed medicine is to be given during the school day. Over-the-counter medication must be provided to school personnel in its original container.

I further agree to hold the Friess Lake School District and above persons harmless in any and all claims arising from the administration of this medication, according to school policy.

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

Date: _____

Signature of Parent

Home Phone: _____

Work Phone: _____

Cell phone: _____