School District of Iola-Scandinavia-Confidential

Health Services: Administration of Over-the-counter medication

Consent form (Wisconsin Statute 118.29)

Students Name:	Date of Birth:
Grade:	School Year:
Bus student: (Circle one) YES NO	

Name of Medication: _____ Reason for medication: _____

****All medication needs to be supplied in the original container with a current expiration date****

Dosage: _____ Frequency: _____ Time: _____

Start Date: _____ Stop Date: _____

***Be specific: The requested dosage and frequency must match the recommendations on the original container. If this request exceeds the manufacturer's recommended dosage, then a physician's signature is required along with the completion of the "Authorization for Medication Consent" form BEFORE the medication can be given at school.**

If the frequency/time is "as needed", list conditions under which the medication should be given:

_____

_____

Any precautions side effects or adverse reactions from taking this medication? (If yes then please describe reaction)_____

_____

Any allergies to mediations? ___Yes ___No (If yes please list what medications and type of reaction)

_____

_____

I hereby give my permission for designated school personnel to give this medication to my child according to the directions stated above and to contact my child's physician if necessary. I agree to notify the school in writing when any change in the above orders is necessary. I further agree to hold the School District of Iola-Scandinavia and its designated school personnel harmless in any and all claims arising from the administration of this medication, according to school policy.

Parent/Guardian Signature: _____ Date: _____

Cell Phone: _____ Daytime Phone: _____ E-mail address: _____