

NONPRESCRIPTION MEDICATION CONSENT FORM

This form must be completed and be on file in the school office in order for school personnel to administer any medications according to Wisconsin State Statute 118.29.

Student Name _____

Name of Medication _____

Time(s) to be Given _____

Reason for Medication _____

Amount/Dose _____

Number of Days _____

PARENT/GUARDIAN

I hereby give my permission to school personnel designated by the school principal to give medication to my child according to the above written instructions.

I also hereby agree to give my permission to the school principal/designee to contact the child's physician.

I further agree to hold the Two Rivers Public School District and all employees harmless in any and all claims arising from the administration of this medication at school.

I agree to notify the school in writing at the termination of this request of when any change in the above is necessary.

_____ Date _____
(Signature of Parent/Legal Guardian)

REMINDER: All medication brought to school must have the following information printed on the container.

- a. Child's full name
- b. Name of drug and dosage
- c. Time to be given
- d. Physician's name and phone number