



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 _____