School District of South Milwaukee
Prescription Medication Administration Consent/Instructions
(Confidential)

Student Name: _____ School: _____

Address: _____ Phone: _____

Parent/Guardian Statement

I hereby request and authorize that _____ receive medication from a school staff member as appointed by the School Principal. I shall supply the school authorities with a properly-labeled bottle of medication. The label shall include the name and telephone number of the pharmacy, the student's name, the name of the prescribing physician, the name of the medication and the amount of dosage to be given. I understand that the school is not responsible for the loss of medication due to carelessness of the student while transporting the medication to school. I understand that all refills must be given to the school in an original medication container.

_____ _____ _____
Parent/Guardian Signature Date Received By

This authorization is hereby terminated.

_____ _____ _____
Parent/Guardian Signature Date Effective Received By

PHYSICIAN'S STATEMENT

Name of Student: _____

The above-named student is under my care and is required to take medication during school hours. Please administer to the above-named student the following medication:

_____
(name of medication)

This medication may be administered by designated school personnel according to the following instructions:

A. Purpose _____
B. Dosage _____
C. Frequency _____ Time of administration _____
D. Special instructions _____
E. Side effect(s) to be alert for _____

These instructions are valid until _____ and do not extend beyond the current school year.

_____
Signature of Prescribing Physician

_____ _____
Telephone Number Date

_____ _____
Signature of Principal Date

THIS FORM SHOULD BE RETURNED TO SCHOOL