NICOLET HIGH SCHOOL HEALTH OFFICE: 414.351.7574

Consent for Administration of Non-Prescription Medications During School Hours

IMPORTANT NOTICE - PARENTAL CONSENT

Non-Prescription drugs may be dispensed by designated school staff only after the parent/guardian has provided written consent and instructions for dispensing the drug to the building principal and/or school nurse. If possible, these medications should be given at home.

Medication must be supplied in the original packaging or container. The medication must be clearly marked with the child's name. A separate consent form must be filled out for each medication and child in the family if it is to be taken at school. For safety and liability reasons, any medications received in envelopes, baggies, or unmarked containers other than the original will not be accepted for staff administration.

Student: ______________________________________ Date of Birth: ______________Grade: ______

Parent/Guardian: ____Daytime Phone ____________________

Note: The 1983 Wisconsin Act 334 states that no school employee except a health professional may be required to administer a drug to a pupil by other than ingestion or oral route.

Name of medication: ___________________________________Dosage:__________________

Form:

⑥ Tablet/capsule ⑥ Liquid ⑥ Inhalation ⑥ Ointment ⑥ Ear/Eye/Nose Drops

Time to be given: _______________________________________ If given on an "as needed" basis, please indicate under what circumstances medication is to be given: ________________

____

How often may it be repeated:____

Reason for medication: ____

Date to begin: _____________ Date to End: ___________________

If designated staff to administer, I hereby release the Board of Education, it's agents and employees, from any and all liability which may result from taking this medication.

Parent/Guardian Signature: ____Date: ______________

Relationship to student: ____

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Consent to Administer Prescription Medications

Student: ____ Date of Birth: _______________

Grade: _______________ Date Form received by School: _________________

To be completed by Physician or Authorized Prescriber
Name of medication: ____
Reason for medication: _______
Form of medication/treatment:
⑥ Tablet/capsule ⑥ Liquid ⑥ Inhaler ⑥ Injection ⑥ Nebulizer ⑥ Ointment

⑥ Other ____

Instructions (schedule and dosage to be given during school hours): ⑥for episodic/emergency use only

____

____

Start: ⑥ Date completed form received ⑥ Other date: ____________________
Stop: ⑥ End of school year ⑥ Other date: ____________________

Restriction and/or important side effects: ⑥ None anticipated ⑥ Yes
If yes, please describe: ____

____
Special storage requirements: ⑥ None ⑥ Refrigerate ⑥ Other ______________________

This student is both capable and responsible for self-administering this medication: (Inhalers only)
⑥ No ⑥ Yes, with supervision ⑥ Yes, without supervision

This student may carry this medication: ⑥ Yes ⑥ No

Please indicate if you have provided additional information:
⑥ On the back side of this form ⑥ As an attachment

Date____________________ Physician's Signature: ____________________________________

Physician/Health Care Provider Name: ____

Office Address: ____________________________________ Phone: ____________ Fax: ______________

To be completed by Parent/Guardian:
I give permission for (name of child)____ to receive
the above medication at school according to standard school policy.

Date: ___________________ Signature: ____

Relationship to student: ____