School Medication Consent Form 

Student's Name	Date of Birth	Grade/Teacher

Name of School	Year	Provider Name & Clinic Phone Number

All Medication will be provided by parent and in its original container or prescription labeled container.
For prescription medication, you may ask your pharmacy to divide the medication into two completely separate, labeled containers, providing one for home and one for school use.

Medication Name	Administration Instructions	Other Info
_____ ☐ Daily ☐ As Needed	Dose: _____ Route:_____ Time Given:_____	Reason for Med: _____
_____ ☐ Daily ☐ As Needed	Dose: _____ Route:_____ Time Given:_____	Reason for Med: _____
_____ ☐ Daily ☐ As Needed	Dose: _____ Route:_____ Time Given:_____	Reason for Med: _____

Please contact me if the following medication side effects or symptoms occur: _____
_____

Other instructions or comments:_____
_____
_____

Inhaler & Epi-Pens Only : This student and his/her parents/guardians have been instructed in self administration and this student may carry an inhaler or Epi-pen and self-administer in school (for grades 6-12 only): ☐ Yes ☐ No

PARENT/GUARDIAN CONSENT:

- I request and authorize that school personnel administer this medication at school and understand that non-medically licensed school personnel will administer the medication.
- I will supply medication in its original, updated, properly labeled container.
- I will notify the school in writing of any changes and obtain a new physician's order.
- I authorize school personnel to exchange information with my child's medical provider regarding this medication or the conditions for which it is prescribed.
- This authorization is for the entire school year (and summer school if attended), unless otherwise indicated.
- I give permission to designated school health staff to notify other appropriate school personnel and classroom teachers of medication administration and possible adverse effects of the medication.
- I understand that all medication is to be transported to and from school by parent or adult and picked up by parent or adult at the end of the school year or it will be discarded.
- I agree to hold the School District, its employees and agents who are acting within the scope of their duties, harmless in any and all claims arising from the administration of this medication at school.
- My signature indicates that I have fully read and understand the above information.

Fax Numbers:
Rock Ledge Primary 920-833-5144
Rock Ledge Intermediate 920-833-9684
Black Creek Elementary 920-984-9303
Seymour Middle School 920-833-9376
Seymour HS Health Office 920-833-5146

_____ _____
Signature of Parent/Legal Guardian Date

_____ _____
Signature of Physician/Practitioner Date

Physician Order Required for: all prescription medication/food supplements , natural products, or over-the-counter medications that exceed the recommended package dose.

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