Appleton Area School District

HEALTH SERVICES * P.O. Box 2019, Appleton, WI 54911 * 920-997-1399 ext. 2106

ADMINISTRATION OF MEDICATION CONSENT

Note: Return the completed form to the main office.
School FAX #: _____
One form for each medication given at school.
New forms required for changes in medication, dosage or time.

All medications administered by AASD staff are only available to students during school hours (7:30am-4:00pm)

Student Name:_____ DOB:_____

School of Attendance:_____ Grade/Room:_____Teacher:_____

Medication Name/Strength:_____ ☐ Prescribed* ☐ Non-Prescribed

Dosage:_____ How Given: _____ Time to be Given:_____
(in mg, ml, etc.)

Should medication be given on Late Start School Days (school starts two hours late)? ☐ Yes ☐ No If yes, what time?_____

Dates Effective (check one): ☐ School Year _____ ***OR*** ☐ Specific Dates: _____ to _____

Medication expiration date, if listed on medication: _____
Expired medication cannot be administered at school. Please make every effort to provide medication that doesn't expire during the school year.

Reason for Medication:_____

If "as needed," list conditions under which medication should be given:_____

Possible Side Effects:_____

*Prescribing Practitioner authorization is **REQUIRED** for all medications that are: **prescription** or in **dosages that exceed typical recommendations**. **Per AASD medication policy, non FDA-approved medications cannot be administered.**

*Prescribing Practitioner's Name:_____ Phone:_____ Fax:_____
(please print)

*Prescribing Practitioner's signature:_____
(please sign)

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 practitioner 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.

Parent/Guardian Signature:_____ Date:_____

Home Phone:_____ Work Phone:_____

I agree to allow my child to transport the medication package (filled or empty) to and from school for the purpose of maintaining medication needed at school for administration and bringing home medication at the end of the school year. Contolled substances may not be transported by students. ☐ YES ☐ NO