HORTONVILLE AREA SCHOOL DISTRICT
HEALTH SERVICES
MEDICATION ADMINISTRATION CONSENT FORM

☐ Greenville Elementary 920-757-7160; **(Fax) 920-757-6972**	☐ Hortonville Elementary 920-779-7911; **(Fax) 920-779-7915**
☐ Greenville Middle School 920-757-7140; **(Fax) 920-757-7141**	☐ Hortonville Middle School 920-779-7922; **(Fax) 920-779-7923**
☐ North Greenville Elementary 920-757-7030; **(Fax) 920-757-7031**	☐ Hortonville High School 920-779-7933; **(Fax) 920-779-7935**

One form for each child and for each medication at school. New form required for changes in medication, dosage, time, etc.

Student's Full Name: _____ Date of Birth: _____

Student's Weight: _____ lbs. Teacher: _____ Grade: _____

Medication Name/Strength: _____ Dosage (in ml, mg, etc.): _____

Route: _____ Time(s) to be given: _____ Expiration date (if listed): _____

If school has an early release, do you want the medications to be given at school? **Yes No**

Effective Date: Entire School Year **OR** Start Date: _____ End Date: _____

Reason for Medication: _____ Possible side effects: _____

MEDICATION CONSENT: I hereby give permission to designated trained school personnel to give medication to my child during the school day, including when away from school property on official school business, according to the written instructions of the practitioner as shown on this form. I also hereby agree to give my permission to the school nurse and/or school personnel to contact the child's physician if needed. I further agree to hold the Hortonville Area School District, and the HASD employee(s) who is (are) administering the medication harmless in any or all claims arising from the administration of this medication at school. I agree to notify the school at the termination of this request or when any change in the above orders is necessary. If self-medication is allowed, I ask that my child be permitted to self-medicate as authorized by my physician and myself. I understand, as the parent, I am responsible to assure that backup rescue medication is available to my child after school hours and traveling to/from and during school-sponsored events.

Parental/Guardian Signature: _____ Date: _____ Phone: _____

Prescribing Practitioner authorization is REQUIRED for all medications that are prescribed, non-FDA approved or in dosages that exceed the manufacturer recommendations

This Section Must be Completed by the Prescribing Practitioner

Prescribing Practitioner's Name (Please Print): _____ Date: _____

Prescribing Practitioner's Signature: _____ Phone: _____ Fax: _____

Prescription Medication Inventory Verification (to be filled out when dropping off and picking up medication)

Date	Inventory	Signature	Signature

Please note: all medications must be picked up by a parent/guardian or designated adult within 5 business days from the last day of school and/or if the child transfers or withdraws to another school. Medications for your child, which remain in the school health room, will be disposed of after the 5th business day of the commencement of school.