NON-PRESCRIPTION MEDICATION

I hereby request and authorize that

_____ _____ of _____
(Student's Name) (Grade) (School)

_____ receive medication from a trained staff member or designated volunteer appointed by the school principal

_____ carry and self-administer (student who is grade 7 or above or individuals approved by the school nurse) medication under the guidance/direction of myself

I shall supply a properly labeled container of medication in its original packaging. The label shall include the student's name, time, and quantity to be given, and name of drug. If administered by trained personnel or designated volunteer, the medication MUST be stored and taken in the health office.

I hereby give permission to my child to take the medication according to the directions stated above. I agree to hold the Muskego-Norway School District harmless in any and all claims arising from the benefits or consequences of this medication which I have prescribed and my child has taken. Furthermore, I agree to hold the district harmless of any responsibility for assuring that the medication is taken. In the event a student refuses to take a medication that a parent/guardian has consented to, District staff will contact the parent as soon as practicable to make them aware of the missed dose.

I agree to notify the school in writing at the termination of this request or when any change in the above order is necessary.

MEDICATION INFORMATION

DRUG: NAME_____ **DOSE/STRENGTH**_____

TIME(s) OF DAY:_____

"TO BE GIVEN AS NEEDED," for what symptoms? _____

Date Effective:_____ **to** _____ ***Note: This consent form must be renewed annually***

SELF ADMINISTRATION

I understand that, if my child self-administers the medication, he/she is not authorized to make this medication available to other students and if he/she does dispense the medication to others, this is cause for immediate revocation of self-administration privilege and will be cause for appropriate disciplinary action against him/her.

_____ _____
(Signature of Parent/Legal Guardian) (Date)

Please return this form to the health room/office. Without the form we cannot dispense the medication.