Student Name______________________________ DOB__________

| 23-24 | M | T | W | T | F | M | T | W | T | F | M | T | W | T | F | M | T | W | T | F | M | T | W | T | F |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| SEPT | | | | | 1 | | 5 | 6 | 7 | 8 | 11 | 12 | 13 | 14 | 15 | 18 | 19 | 20 | 21 | 22 | 25 | 26 | 27 | 28 | 29 |
| Time Given | | | | | | | | | | | | | | | | | | | | | | | | | |
| OCT | 2 | 3 | 4 | 5 | 6 | 9 | 10 | 11 | 12 | 13 | 16 | 17 | 18 | 19 | | 23 | 24 | 25 | 26 | 27 | 30 | 31 | | | |
| Time Given | | | | | | | | | | | | | | | | | | | | | | | | | |
| NOV | | | 1 | 2 | 3 | 6 | 7 | 8 | 9 | 10 | 13 | 14 | 15 | 16 | 17 | 20 | 21 | | | | 27 | 28 | 29 | 30 | |
| Time Given | | | | | ER | | | | | | | | | | | | | | | | | | | | |
| DEC | | | | | 1 | 4 | 5 | 6 | 7 | 8 | 11 | 12 | 13 | 14 | 15 | 18 | 19 | 20 | 21 | | | | | | |
| Time Given | | | | | | | | | | | | | | | | | | | | | | | | | |
| JAN | | | 3 | 4 | 5 | 8 | 9 | 10 | 11 | 12 | | 16 | 17 | 18 | 19 | 22 | 23 | 24 | 25 | 26 | 29 | 30 | 31 | | |
| Time Given | | | | | | | | | | | | | | | ER | | | | | | | | | | |
| FEB | | | | 1 | 2 | 5 | 6 | 7 | 8 | 9 | 12 | 13 | 14 | 15 | | | 20 | 21 | 22 | 23 | 26 | 27 | 28 | 29 | |
| Time Given | | | | | | | | | | | | | | | | | | | | | | | | | |
| MARCH | | | | | 1 | 4 | 5 | 6 | 7 | 8 | 11 | 12 | 13 | 14 | 15 | 18 | 19 | 20 | 21 | 22 | | | | | |
| Time Given | | | | | | | | | | | | | | | | | | | | ER | | | | | |
| APRIL | 1 | 2 | 3 | 4 | 5 | 8 | 9 | 10 | 11 | 12 | 15 | 16 | 17 | 18 | 19 | 22 | 23 | 24 | 25 | 26 | 29 | 30 | | | |
| Time Given | | | | | | | | | | | | | | | | | | | | | | | | | |
| MAY | | | 1 | 2 | 3 | 6 | 7 | 8 | 9 | 10 | 13 | 14 | 15 | 16 | 17 | 20 | 21 | 22 | 23 | 24 | | 28 | 29 | | |
| Time Given | | | | | | | | | | | | | | | | | | | | ER | | | | | |

Teacher____________________Grade__________Room #_____________

MEDICATION_______________________________________________

Dosage: __________________________________ Time: ___________

Initial Signature

______ ________________________________________________

______ ________________________________________________

______ ________________________________________________

______ ________________________________________________

______ ________________________________________________

CODES
- S - Start Day
- DC - Discontinued
- NG – Not Given
- AB – Absent
- ER – Early Release
- NS – No School (holiday, snow, etc)

# School District of Horicon
# Medication Consent Form

****All Over the counter medication must be in its original container with label intact****
**Prescription medication must be in a properly labeled pharmacy bottle**

**Students Name**_______________________________________________________ **Date**______________

Parent Daytime Phone________________________________________________________________

**Section I: For NON-PRESCRIPTION Medication**

1. Name of Medication_________________________________Amount/Dose_____________________
   Times to be given__________________________________Duration:_______________________
   Reason for Medication___________________________________________________________
2. Name of Medication_________________________________Amount/Dose_____________________
   Times to be given__________________________________Duration:_______________________
   Reason or Medication___________________________________________________________

**Section II: For Prescription Medications:**
*This portion must be completed by a physician, physician's assistant or nurse practitioner prior to the student taking medication at school. Medications will be stored and dispensed in the school's Main Office. The exception to this is epi-pens and inhalers, which may be carried by the student with physician and nurse written approval.

| Medication | Route | | | Conditions Under Which to Medicate | Contact Physician When: |
|---|---|---|---|---|---|
| 1) | | | | | |
| 2) | | | | | |
| 3) | | | | | |

*Students with asthma inhalers or epi-pens for allergic reactions:
❐ This student may carry and self-administer medication.
❐ This student needs supervision and/or assist with administration.

I agree to retain the power to direct, supervise, decide, inspect and oversee the administration of such medication(s). Direct contact shall be made with me at any time should you have any questions.

Hospital/Clinic/Office:_____________________________Address:______________________________

Physician's Signature:_____________________________ Phone #:_______________ Date ___________

**Section III: Parental Permission**
I hereby give permission to the people named below to give the medication(s) to my child/ward according to the directions stated above and further authorize them to contact the child's/ward's physician. I agree that the school district, its employees and agents who act within the consent granted by this document, shall not be liable for any claims that I may have arising from the administration of this medication to my child/ward at school.

Signature of Parent/Guardian___________________________________________Date________________

Address:_____________________________________________________Phone #:_____________

**Administrative Authorization:**
The following staff is authorized to dispense medication: designated office staff or school nurse

Principal's Signature:______________________________________________________Date 7/01/23