Student Name: _____ DOB: _____

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

Teacher: _____ Grade: _____ Room #: _____

MEDICATION: _____

Dosage: _____ Time: _____

Initial Signature

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

CODES

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

Horicon School District
Medication Consent Form

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

Student Name: _____ DOB: _____ Date: ___/___/___

Home Phone: _____ 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 for 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	Dose	Frequency	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 assistance with administration.

I hereby give permission for authorized school personnel to administer the above named medication/s to the child listed above.

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 according to the directions stated above and further authorize them to contact the child's physician with any questions. 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 Staff or School Nurse.

School Nurse Signature: _____ Date: _____