Student Name_____ DOB_____

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

# 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___/___/___**

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 | | | 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, I inspect and oversee the administration of such medication(s). Direct contact shall me 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 7/01/18