Student Name_____ DOB_____

24-25	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	9	10	11	12	13	16	17	18	19	20	23	24	25	26	27	30				
Time Given																									
OCT		1	2	3	4	7	8	9	10	11	14	15	16	17	18	21	22	23	24		28	29	30	31	
Time Given																									
NOV					1	4	5	6	7	8	11	12	13	14	15	18	19	20	21	22	25	26			
Time Given					ER																				
DEC	2	3	4	5	6	9	10	11	12	13	16	17	18	19	20										
Time Given																									
JAN				2	3	6	7	8	9	10	13	14	15	16	17	20	21	22	23	24	27	28	29	30	31
Time Given															ER										
FEB	3	4	5	6	7	10	11	12	13			18	19	20	21	24	25	26	27	28					
Time Given																									
MARCH	3	4	5	6	7	10	11	12	13	14	17	18	19	20	21	24	25	26	27	28	31				
Time Given															ER										
APRIL		1	2	3	4	7	8	9	10	11	14	15	16	17	18	21	22	23	24	25	28	29	30		
Time Given																									
MAY				1	2	5	6	7	8	9	12	13	14	15	16	19	20	21	22	23		27	28		
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: <u>designated office staff or school nurse:</u>

Principal's Signature: _____Date <u>7/01/24</u>