DATE_____

SCHOOL DISTRICT OF GOODMAN-ARMSTRONG CREEK
PARENT MEDICATION CONSENT FORM

Childs full name_____Grade_____
Name of drug_____
Dosage (amount) to be given_____Time to administer_____
Number of days_____
Name of physician prescribing medication_____Phone_____
Reason for medication_____

I hereby give permission to school personnel authorized to give the medication(s) to my child according to the direction stated above and further authorize them to contact the child's physician. I agree to hold the School District of Goodman-Armstrong Creek, it's employees and agents who are acting with the scope of their duties harmless in any and all claims arising from the administration of this medication at school.

_____ _____ _____
Parent/Guardian Signature Date Telephone Number

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Date_____

PHYSICIAN REQUEST FOR MEDICATION ADMINISTRATION

Childs full name_____Grade_____
Parent/guardian name_____Phone_____
Physician's name_____Phone_____
Licensed in WI Yes_____ No_____
Diagnosis

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_____
_____
Medication(s)_____
Dosage_____Duration_____
Route_____Date effective_____
Time to administer_____Expires_____

If PRN medication, state condition under which medication is to be given. State specific conditions under which contact should be made with you in relation to the condition or reactions of the student receiving the medication(s)_____

Medication may, at times be administered by NON-medically trained personnel. Please state instructions in language of the lay person.

_____ _____
Physicians' Signature Date