***NON PRESCRIPTION MEDICATION* PARDEEVILLE SCHOOL DISTRICT CONSENT FORM**

Elementary: (608) 429-2151 Fax (608) 429-4807
Middle/High School: (608) 429–2153 Fax (608) 429-2277

SCHOOL (circle one): Elementary Middle School High School

STUDENT'S NAME_____ DOB_____ Grade _____

Address_____Phone_____

Medications are to be given at home whenever possible. If it is necessary for a student to receive medications at school, all appropriate portions of this form **MUST** be completed before medication can be given at school.

One form for **EACH** medication is required.

All medication must be in the original over-the-counter container.

Name of medication_____Date Start_____End_____
Dosage_____Frequency_____

Route (circle choice) **ORAL TOPICAL**

Possible Side Effects_____
If medicine is to be given when needed, describe conditions under which to administer_____
_____

PARENT/GUARDIAN CONSENT: (Complete for all non-prescription medications/procedures at school).

- I request and authorize that this medication be administered at school by school personnel.
- I will supply medication in its original, updated, properly labeled container.
- This order is in effect for this school year unless otherwise indicated.
- I understand that the medication must be brought to school by an **ADULT**.
- I understand that when medication at school is no longer needed, an **ADULT** will pick up the remaining medication. **It will not be sent home with the child.**
- I understand that medication will be given by non-medically trained school personnel.
- I agree to hold the School District, its employees and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication at school.

----------REQUIRED SIGNATURES----------

The above medication is to be administered during the school day in accordance with the above instructions and agreements. I agree to accept communication about student/medication and understand the medication will be given by non-medically trained school personnel.

Parent/Guardian Signature gives permission for the school to dispense medication/treatment as described above and allow discussion of medical conditions with Physician/practitioner. Parent/Guardian is responsible for contacting school if the plan is to be changed/withdrawn.

Parent/Guardian Signature_____Date_____

(Print - Parent/Guardian Name): _____

02/2024