HAMILTON SCHOOL DISTRICT
Sussex, WI

MEDICATION PERMISSION FORM

Prescription medication must be in a pharmacy labeled container and include:

- student's full name,
- name of drug, dosage, effective date and administration
- instructions including time to be given,
- health care provider's name and phone number;

Non-prescription medication must be in the original manufacturer's package and the package must list the ingredients and recommended dose.

Student (print) _____ Grade_____
Address _____ School_____
Parent/Guardian's Name _____ Address_____
Home Phone Number _____ Work Phone Number_____
Physician's/Health Care Provider's Name_____
Address_____
My Physician can be contacted at _____ Fax _____
Name of Medication:_____ (Prescription:__Yes__No)
Expiration of Medication _____ Quantity of Medication_____
Dosage:_____
Administration Instructions
Time(s) to be given:_____ Termination Date:_____
Reason for medication:_____
Known side effects:_____
******If an Epi Pen is self-administered, student must immediately report use to office or health room personnel. (**9-1-1 will automatically be called**)

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It is the responsibility of the student's parent/guardian to deliver medication as necessary and appropriate to the school office or health room personnel. All unused medication must be picked up by the parent/guardian within one week of the termination date of administration or on the last day of school, as applicable, unless other arrangements have been made with the school.

I give my permission for designated school district personnel to administer the medication described above as directed and to contact the student's physician/health care provider as necessary.

Staff members can be informed about the student's health concern in order for the student to receive appropriate care.

I agree to hold the Hamilton School District employee administering the medication harmless in any claims arising from the administration of this medication at school or during a school-sponsored activity.

Parent/Guardian Signature_____ Date:_____
Physician's/Health Care Provider's Signature_____Date:_____
Student Signature (18 or older)_____ Date:_____

This form is valid for one school year.

Hamilton School District
Administering Medication Procedures

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