HAMILTON SCHOOL DISTRICT
Sussex, WI

GENERAL MEDICATION PERMISSION FORM

(For Inhaler or Epinephrine Autoinjector see 453.4-Exhibit (2) or (4))

(Submit one form for each medication)

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; and
- 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.

Quantity requirements:
- Daily Medications: One month supply only. *If half pills are needed for dosing, the pills must be cut at home.*
- As needed/PRN medication: In 30 count or less packaging

Student (print) _____Grade_____
Address _____School_____
Parent/Guardian's Name _____
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:_____
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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 authorized or 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 453.4-Exhibit (1)
Administering Medication Procedures

APPROVED:	June 16, 1980
REVISED:	October 15, 1984
	February 19, 1990
	February 5, 1991
	May 15, 1995
	May 7, 1996
	August 16, 1999
	July 17, 2000
	June 3, 2003
REVIEWED:	June 30, 2004
REVISED:	June 19, 2006
REVIEWED:	June 18, 2007
REVISED:	June 3, 2008
	August 17, 2009
	June 18, 2012
REVIEWED:	June 15, 2015
REVISED:	June 1, 2021
	July 18, 2022