Received _____
Initials _____

# SCHOOL DISTRICT OF SPOONER

## SCHOOL HEALTH SERVICES

801 County Hwy A
Spooner, WI 54801

| | |
|---|---|
| Spooner Elementary | 715-635-2174 |
| | 715-635-7984 (FAX) |
| Spooner Middle School | 715-635-2173 |
| | 715-635-9621 (FAX) |
| Spooner High School | 715-635-2172 |
| | 715-635-7074 (FAX) |


### ADMINISTRATION OF *PRESCRIPTION* MEDICATION CONSENT

Student Name:_____ Grade: ____ D.O.B.: _____

☐ Elementary School ☐ Middle School ☐ High School

Prescription Medication: _____

Dosage: _____ Route: _____ Time: _____

Starting Date: _____ Termination Date:_____

Reason for Medication: _____

If "as necessary," conditions under which medication should be given: _____

_____

Precautions, possible unfavorable reactions, and/or interventions:_____

_____

Prescribing Physician Name (please print):_____ Phone: _____

***Physician Signature:** _____

I hereby give my permission for designated school personnel to give this medication to my child according to the directions state above and for the school nurse to contact my child's physician if necessary.

**A physician's written, signed statement and pharmacy-labeled container must be supplied by the parent/guardian if medication to be given during the school day. Medication must be provided to school personnel in its original container.**

I further agree to hold the School District of Spooner and above persons harmless in any and all claims arising from the administration of this medication, according to policy, at school.

I agree to notify the school in writing when any change in the above orders is necessary.

**This medication needs to accompany the student on school related field trips ___YES___NO**

**Date:** _____ _____ **Home Phone:** _____

*Signature of Parent* **Work Phone:** _____