

SCHOOL DISTRICT OF SPOONER

SCHOOL HEALTH SERVICES

801 County Hwy A
Spooner, WI 54801

**Stock Tylenol 325mg & Ibuprofen 200mg available at the MS/HS.
This form must be signed for med to be given at school.**

ADMINISTRATION OF STOCK MEDICATION CONSENT FOR 2018-19 SCHOOL YEAR

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

School: Elementary School Middle School High School

Medication Name: 325 mg Tylenol 200 mg Ibuprofen
 Hydrocortisone Cream Burn Cream Antibiotic Ointment

Starting Date: _____ Termination Date: _____

Reason for Medication: _____

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

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

All stock medications will be given per the dosage recommendations on the bottle based on age/weight. Exceeding dosage recommendations will need written documentation from a physician.

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

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.

Parent/Guardian Signature (*Students 18 years of age may sign their own request*)

Date

Name of Parent/Guardian (*Please print*)

Phone Number

