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)

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

ADMINISTRATION OF MEDICATION CONSENT

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

School: ☐ Elementary School ☐ Middle School ☐ High School

Medication Name:______________________________ ☐ Prescription ☐ Non-Prescription

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:** _____________

Student Name

INITIALS AND SIGNATURE OF PERSON GIVING MEDICATION		TOTAL OF MEDICATION RECEIVED			TOTAL OF MEDICATION RECEIVED		
INITIALS	SIGNATURE	DATE	NO.	INITIALS	DATE	NO.	INITIALS

MEDICATION ADMINISTRATION

DATE	INITIALS	DOSE	DATE	INITIALS	DOSE	DATE	INITIALS DOSE