

DODGEVILLE SCHOOL DISTRICT MEDICATION CONSENT FORM (Physician Information/Signature Needed-After completing this form, you will have to print and have your physician complete/sign their portion. You will need to complete one form for each student who receives medication at school.

STUDENT:

DOB:

SCHOOL:

SCHOOL YEAR:

TEACHER:

PHYSICIAN:

ALLERGIES:

MEDICATION	DOSAGE	AMOUNT TO GIVE	TIME TO GIVE	REASON FOR MEDICATION	IF ONLY 'AS NEEDED' STATE CONDITIONS FOR GIVING	DATE TO DISCONTINUE; ALL MEDICATIONS ARE DISCONTINUED AT THE END OF THE SCHOOL YEAR

Parent /Legal Guardian Must complete this section for over-the-counter and prescription medications before they will be given.

I hereby authorize the school to give medication(s) to my child according to the directions stated above, and give the school consent to contact my child's physician. I agree to hold the Dodgeville School district, its employees, and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication at school. I also agree to inform the school in writing immediately of any change in the medication order. I will supply limited quantities of the medication in the original container labeled plainly with child's full name, name of the drug, dosage of the drug, time, quantity to be given, and physician's name.

DODGEVILLE SCHOOL DISTRICT MEDICATION CONSENT FORM (Physician Information/Signature Needed-After completing this form, you will have to print and have your physician complete/sign their portion.

Signature of Parent/Legal Guardian

Date:

Contact Phone Number

Signature of School Nurse

Date:

THE FOLLOWING SECTION MUST BE COMPLETED BY THE PHYSICIAN FOR PRESCRIPTION MEDICATION TO BE GIVEN AT SCHOOL

Please state any conditions where contact should be made with the physician concerning the condition or reaction of the student receiving the medication:

The undersigned physician orders the administration of the medication(s) as described above and agrees to accept communication about the student/medication. The physician also understands that non-medically trained personnel will give medications.

Physician Name (printed): _____

Contact Phone Number: _____

Physician's Signature

Date:

Name of Hospital/Clinic