

SUN PRAIRIE AREA SCHOOL DISTRICT

501 South Bird Street
Sun Prairie, WI 53590

**NON-PRESCRIPTION
(OVER THE COUNTER)
MEDICATION ADMINISTRATION CONSENT FORM**
(Please print clearly)

Student name: _____ Parent/Guardian name: _____

Phone #: _____ School: _____ Grade: _____ Date of birth: _____

Practitioner name: _____ Phone #: _____

Name of medication & strength (e.g. mg.): _____ Time to be given: _____

Dosage: _____ How Often: _____

Reason for medication: _____

Considerations/side effects: _____

Duration: From _____ to _____

I hereby give my permission to the Sun Prairie Area School District to administer medication to my child according to the directions stated above and further authorize them to contact the child's practitioner if warranted (should the need arise for the safety of my child and other students).

I will notify the school in writing whenever this consent is withdrawn prior to the end of the duration period stated above.

Signature of Parent/Legal Guardian Date

NOTE: Medications must be brought to school in the original container labeled with student's name.