101 E Northland Avenue
Appleton, WI 54911

HEALTH SERVICES

Administration of Medication Consent

PARENT/GUARDIAN STATEMENT

Use one form for each medication. PLEASE PRINT

Student Name: _____ *Date of Birth:* _____

Parents Name: _____

Campus: _____ *Grade/Room:* _____

Medication Name: _____ *Prescribed*:* ☐ *Non-Prescribed:* ☐

Dosage (in mg, ml, etc.): _____ *How Given:* _____ *Time to be Given:* _____

Starting Date: _____ *Termination Date:* _____

Reason for Medication: _____

_____

_____

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

_____

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

_____

Prescribing Physician Name: _____ *Phone:* _____

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

I further agree to hold St. Francis Xavier Catholic School System and above person harmless in any and all claims arising from the administration of this medication at school.

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

Parents Signature: _____ *Date:* _____

Home Phone: _____ *Cell Phone:* _____

**A physician written, signed statement and a pharmacy labeled container with accurate dosage and administration instruction must be supplied by the parent/guardian.*

I agree to allow my child to transport the medication container (filled or empty) to and from school for the purchase of maintaining medication needed at school for administration. Yes ☐ No ☐

HEALTH SERVICES
Administration of Medication Consent

*Physician Statement**

One form for each medication given at school

Student Name: _____ Date of Birth: _____

Campus: _____ Grade/Room:

Medication Name**/Strength: _____

Dosage**: _____ Route**: _____ Frequency: _____

Starting Date: _____ Termination Date: _____

Reason for Medication: _____

_____

_____

_____

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

_____

_____

Prescribing physician name: _____

Phone: _____ FAX: _____

Address: _____

Signature of Physician: _____ Date: _____

ST. FRANCIS XAVIER

101 E Northland Ave
Appleton, WI 54911
920-735-9380

*Form to be **completed by R.N. or M.D. and signed by M.D.** – one medication per form.
**A new physician statement will be needed for any changes in medication, dosage, route, or frequency.