Medication Consent Form

RN verified _____

Student_____ Grade_____ Date_____

Date of Birth_____ School_____ Teacher_____

All medications administered by AASD staff are only available to students during school hours (7:30 a.m.- 4:00 pm), must not be expired, and in a properly labeled pharmacy box/bottle. Ask your pharmacy for any needed labels or containers.

Section 1: Prescription Medications (Provider Signature Required On Page 2)

Medication Name/Strength	Dose	Route*	Time	Reason/Diagnosis	Expiration Date

**Route = oral, inhaled, topical, injectable, etc.*

Section 2: Over-the-Counter (OTC) Medications

Medication Name/Strength	Dose	Route*	Time	Reason/Diagnosis	Expiration Date

**Route = oral, inhaled, topical, injectable, etc.*

Is the student authorized to carry and self-administer OTC medication? ☐ **Yes** ☐ **No**

If yes, where will this medication be kept? ☐ **Backpack** ☐ **Locker** ☐ **Other**_____

Parent Consent for Medication Administration

I hereby give my permission to the person(s) designated by the building administrator or designee, to give the above medication(s) to my child according to the directions stated above and further authorize them to contact and share medical information about my child with the physician indicated below. I agree to hold the Appleton Area School District and its employees who are acting within the scope of their duties harmless from any and all claims arising from the administration of this medication. I agree to pick up any remaining medication by the last day of school or will give the school authorization to dispose of all remaining medication(s). I understand that a completed and signed Medication Administration Consent Form is required before a prescription drug can be administered. This information will be shared with AASD staff on a need-to-know basis for the health and safety of my child.

Parent/Guardian Signature_____ Date_____

The Physician Information/Consent section must be completed whenever the following conditions exist:

- Any OTC medication product that contains aspirin;
- An OTC medication is to be given daily for greater than 10 days in a row;
- An OTC medication is to be given in a dosage other than the recommended therapeutic dose; or
- Any prescription medication

Any medication/substance that is not FDA-approved may not be given by AASD staff.
Expired medications may not be given by AASD staff.

Provider Information/Consent

Print Name of Provider_____ Clinic Name _____

Phone Number_____ Fax Number _____

Address _____

Signature of Provider_____ Date_____

Is the student authorized to carry and self-administer prescription medication? ☐ **Yes** ☐ **No**

If yes, where will this prescription medication be kept? ☐ **Backpack** ☐ **Locker** ☐ **Other**_____

I agree to allow my student to transport the medication package (filled or empty) to and from school for the purpose of maintaining medication needed at school for administration and bringing home medication at the end of the school year. *Controlled substances may not be transported by students.*

☐ Yes
☐ No

**Note to Health Care Provider: This document serves as medication and treatment orders.*