



Neenah Joint School District
410 S Commercial St.
Neenah, WI 54956

Picture

Medication Consent Form

Student _____ Date _____ Grade _____

Date of Birth _____ School _____ Teacher _____

Address _____ City _____ Zip Code _____

Emergency Contacts:

Name _____ Number _____ Relationship _____

Name _____ Number _____ Relationship _____

Name _____ Number _____ Relationship _____

Section 1: PRESCRIPTION MEDICATIONS

Medication	Dose	Route*	Time	Diagnosis

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

Section 2: OVER-THE-COUNTER (OTC) MEDICATIONS

Medication	Dose	Expiration Date	Route*	Time	Diagnosis

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

Medication Rules:

- All medications must be brought in original packaging with label/instructions for use.
- Prescription medication must have a pharmacy label attached.
- No baggies/envelopes of medications will be accepted.
- All controlled substances must be brought in by a parent/guardian.

-OVER-

Student Name:_____ Student DOB:_____

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 Neenah Joint 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 NJSD 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 herbal or other medication not FDA approved;
- Any OTC medication product that contains aspirin;
- An OTC medication is to be given daily for greater than 10 days;
- An OTC medication is to be given in a dosage other than the recommended therapeutic dose; or
- Any prescription medication

Physician Information

Print Name of Provider_____ Clinic Name_____

Phone Number_____ Fax Number_____

Address_____

Signature of Provider_____ Date_____

Provider NPI # _____

By signing this form you are acknowledging this medication/Health plan is medically necessary for school