SCHOOL DISTRICT OF WISCONSIN DELLS
CONNECT • INSPIRE • ACHIEVE
Everyone. Every day.

MEDICATION CONSENT FORM

School Year: 2026-2027
WDHS ( ) WDMS ( ) WDES ( )

Medications are to be administered at home whenever possible. If it is necessary for a student to receive medication at school, all appropriate portions of this form must be completed before medication can be given.

One form is required for EACH medication

Medication MUST be in its original prescription or over-the-counter container with a valid expiration date and student's name.

Prescription Medications: This form must be signed by both parent/guardian & provider.
Non-prescription Medications: This form to be signed by parents/guardian only, unless requested dose exceeds the recommended dose on package.

Student:_____**DOB:**_____**Grade:**_____

Healthcare Provider:_____**Phone:**_____**Fax:**_____

Parent/Guardian:_____**Phone:**_____**Alt:**_____

MEDICATION:

Medication Name:_____Strength:_____Dose:_____

Route to be given: ( ) **oral** ( ) **inhaled** ( ) **injectable** ( ) **topical** ( ) **eye** ( ) **ear** ( ) **other**_____

Reason for taking:_____Possible Side Effects:_____

Time: ( ) **Scheduled at:**_____ ( ) **As Needed, for the following symptoms:**_____

PARENT/GUARDIAN CONSENT: (Review each item before signing)

- **Delivery & Packaging:** A parent/guardian must deliver and pick up all medication in its original, dated, properly labeled container. (tip: request an extra labeled bottle from your pharmacy)
- **Emergency Self-Carry Only:** Students are strictly prohibited from carrying any medication unless it is a life-saving emergency device (Inhaler, Epinephrine, or Glucagon) as authorized below by their healthcare provider.
- **Timeline & Updates:** This authorization is valid for the current school year only. Any dosage or medication adjustments require a new provider order and written notification.
- **Med Administration:** I authorize school personnel to administer this medication and understand that non-medical, trained school staff may perform this duty.
- **Information Sharing:** I authorize school personnel to exchange information verbally, in writing or electronically with school personnel and/or my child's healthcare provider regarding this medication or the conditions for which it is prescribed.
- **Activities & Travel:** I am responsible to assure that backup rescue medication is available to my child outside of school hours, during travel, and at extracurricular events.
- **Liability Waiver:** I agree to hold the School District of Wisconsin Dells, its employees & agents who are acting within the scope of the duties harmless in any & all claims arising from the administration of this medication.

FOR EMERGENCY MEDS ONLY: (Student May Self-Carry/Self-Administer)

( ) Yes ( ) No **Inhaler** ( ) Yes ( ) No **Epinephrine** ( ) Yes ( ) No **Glucagon**

My signature indicates that I have fully read and understand the above information.

_____ _____ _____
Signature of Parent/Legal Guardian **Date** **Phone Number**

HEALTHCARE PROVIDER ORDER & AUTHORIZATION:

The above medication is to be administered during the school day in accordance with the above written instructions. I agree to exchange information verbally, in writing or electronically about the student/medication/condition for which it is prescribed. I understand that non-medically trained school personnel may administer this medication.

FOR EMERGENCY MEDS ONLY: (Student May Self-Carry/Self-Administer & has been fully instructed):

( ) Yes ( ) No **Inhaler** ( ) Yes ( ) No **Epinephrine** ( ) Yes ( ) No **Glucagon**

_____ _____ _____
Signature of Licensed Healthcare Provider **Date** **Clinic**