Edgerton School District
Medication Consent Form

Student Name:_____ DOB:_____ Grade: _____

◊ Community Elementary School ◊ Yahara Valley Elementary School ◊ Middle School ◊ High School

Fax: 608-884-8548 Fax:608-884-4975 Fax: 608-884-2279 Fax: 608-884-7969

Primary Phone#:_____ Primary Address:_____

Over the Counter Medications (to be completed by Parent/Guardian)							School shall contact the clinic for any of the following symptoms:
Medication Name:	Dosage	Route	Daily or As Needed	Time	Duration	Diagnosis/ Instructions/ Reason for Administration	
					From: To:		
					From: To:		
					From: To:		
					From: To:		

Prescription Medications (to be completed by Practitioner)							School shall contact the clinic for any of the following symptoms:	Emergency Medication Only. Practitioner to initial box below if student is able to carry and self-administer.ie Inhaler, Epinephrine.
Medication Name:	Dosage	Route	Daily or As Needed	Time	Duration	Diagnosis/ Instructions/ Reason for Administration		
					From: To:			
					From: To:			
					From: To:			
					From: To:			

PRACTITIONER INFORMATION (needed for all prescription medication administered at school):

Practitioner Name: _____ Phone: _____

Address: _____

The above prescriptions medications will need to be administered at school:

Practitioner's Signature:_____ Date: _____

Parent/Legal Guardian Consent (needed for all medication at school):

Medication will be provided by parent and in its original container or prescription labeled container.

I hereby give permission for school personnel to administer the above medication(s) to my child according to practitioner's and/or my instructions and authorize them to contact the practitioner if there is a question or concern. I further authorize the practitioner to render treatment to my child, as appropriate and necessary, arising out of administration of the medication.

_____ _____

Signature of Parent/Legal Guardian Date

In the event that your child will have some unused doses of medication left at the end of the school year, please advise the school on how you would like the medication handled by completing the following:

☐ I will arrange to pick up the unused portion of my child's medication.

☐ Dispose per district policy the unsused portion of my child's medication.