Dodgeville School District Medication Consent

Student: _____ Birthdate: _____School: _____ School Year _____
Grade: _____Teacher: _____ Physician: _____ Allergies _____

Medication	Dosage	Amount to Give	Time to Be Given	Reason for Medication	If only "As Needed" state conditions for giving	Date to Discontinue; All medications are discontinued at end of school year

Parent /Legal Guardian Must complete this section for over-the-counter and prescription medications before they will be given.
I hereby authorize the school to give medication(s) to my child according to the directions stated above, and give the school consent to contact my child's physician. I agree to hold the Dodgeville School district, its employees, and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication at school. I also agree to inform the school in writing immediately of any change in the medication order. I will supply limited quantities of the medication in the original container labeled plainly with child's full name, name of the drug, dosage of the drug, time, quantity to be given, and physician's name.

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

_____ _____
Signature of School Nurse Date

The following section must be completed by the physician for prescription medication to be given at school.
Please state any conditions where contact should be made with the physician in regard to the condition or reaction of the student receiving the medication: _____
The undersigned physician orders the administration of the medication(s) as described above and agrees to accept communication about the student/medication. The physician also understands that medications will be given by non-medically trained personnel.

Physician Name (printed): _____ Contact phone number: _____

_____ _____ _____
Physician's Signature Date Name of Clinic / Hospital