MENASHA JOINT SCHOOL DISTRICT
ADMINISTRATION OF MEDICATION CONSENT

Name of Student_____ DOB:_____ Phone Number_____

Medication Name_____

Dosage_____ Time to be Given_____

Route (Circle one): By Mouth Inhalation Injection

Start Date_____ Discontinue Date_____

Reason For Medication_____

Precautions_____

Prescribing Physician_____

Physician's Address_____ Physician's Phone_____

Physician's Signature_____

I hereby give my permission to school personnel to give the medication to my child according to the directions stated above and to contact the child's physician if necessary.

I understand it is my responsibility to see that the medication is delivered to the school office and to pick up any remaining medication within one week after the last day of the school year. Medication remaining at school beyond this stated time will be discarded.

I further agree to hold the Menasha Joint School District and above person harmless in any and all claims arising from the administration of the medication at school. I agree to notify the school in writing when any change in the above order is necessary.

_____ _____

Signature of Parent/Legal Guardian Date

Approved by:_____ _____

Signature of School Administrator Date

Revised 1-08

Student's Name_____ Medication_____

School Year: 2008 – 2009 Time to Administer_____ Dosage_____/Route_____

PLEASE ENTER TIME DRUG WAS GIVEN AND INITIAL (Initials = Swallowed without difficulty–1 unit)

	Aug.	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	March	April	May	June
1		H		W		H	W	W			
2				W		H				W	
3				H		W				W	
4			W			W			W		
5			W						W		
6		W			W						W
7		W			W		W	W			W
8				W			W	W			
9				W						W	
10						W			H	W	
11			W			W			W		
12			W						W		
13		W			W				H		W
14		W			W		W	W	H		W
15				W			W	W	H		
16				W					H	W	
17						W			H	W	
18			W			W			W		
19			W						W		
20		W			W				H		W
21		W			W		W	W			W
22				W			W	W		H	
23				W			H			W	
24					H	W				W	
25			W		H	W			W	H	
26			W		H				W		
27		W		H	W						W
28		W		H	W		W	W			W
29				W	H	H		W			
30			H	W	H					W	
31			H		H	W				W	
RN Sign											

KEY: *A* = Absent *R* = Refused *P* = Problem noted, see comments *O* = No show *W* = Weekend *H* = Holiday *N* = No medication available

Staff Signature(s):_____

Comments:_____

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