School District of Stockbridge

110 School Street P.O. Box 188 Stockbridge, WI 53088
920-439-1158 • FAX 920-439-1150

Chad Marx
Superintendent
chamarx@stockbridge.k12.wi.us

Curt Meshak
Principal
curmeshak@stockbridge.k12.wi.us

HEALTH SERVICES
ADMINISTRATION OF MEDICATION CONSENT

(Use one medication per form)

Student Name _____ D.O.B. _____

Medication Name _____

Prescribed* _____ Non-prescribed _____

Dosage: _____ Route:_____ Time: _____

Starting Date: _____ Ending Date:_____

Reason for Medication:_____

_____

If, "AS NECESSARY", conditions under which medication should be given:_____

_____

_____

Precautions, possible untoward reactions, and/or interventions:_____

_____

_____

Prescribing physician name: _____ Phone:_____

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

I further agree to hold the Stockbridge School District harmless in any and all claims arising from the administration of this medication at school.

I agree to notify the school in writing when any change in the above orders is necessary.

_____ _____

Signature of Parent/Guardian Date Date

A physician written, signed statement or pharmacy labeled container must be supplied by the parent/guardian.