Neenah Joint School District
410 S Commercial St.
Neenah, WI 54956

Picture

Medication Consent Form

Student_____ Date_____ Grade_____

Date of Birth_____ School_____ Teacher_____

Address_____ Parent/Guardian_____

City_____ Zip Code_____ Home Phone_____

Emergency Contacts:

Name_____ Number_____ Relationship_____

Name_____ Number_____ Relationship_____

Name_____ Number_____ Relationship_____

Section 1: OVER-THE-COUNTER (OTC) MEDICATIONS

Medication	Dose	Route*	Time	Diagnosis	Expiration date

*Route = oral, inhaled, topical, injectable, etc.
**All over the counter medications must be in the original container.

SECONDARY STUDENTS ONLY (grades 6-12)

☐ Yes, my child may carry the above medication(s) while at school. If Yes, must have OTC agreement signed.
☐ No, my child will leave the above medication(s) in the health office.

Section 2: PRESCRIPTION MEDICATIONS

Medication	Dose	Route*	Time	Diagnosis

*Route = oral, inhaled, topical, injectable, etc.
**All prescription medications must be in a properly labeled pharmacy box/bottle.

-OVER-

Parent Consent for Medication Administration

I hereby give my permission to the person(s) designated by the building administrator or designee, to give the above medication(s) to my child (name) _____ according to the directions stated above and further authorize them to contact and share medical information about my child with the physician indicated below. I agree to hold the Neenah Joint School District and its employees who are acting within the scope of their duties harmless from any and all claims arising from the administration of this medication. I agree to pick up any remaining medication by the last day of school or will give the school authorization to dispose of all remaining medication(s). I understand that a completed and signed Medication Administration Consent Form is required before a prescription drug can be administered. This information will be shared with NJSD staff on a need to know basis for the health and safety of my child.

Parent/Guardian Signature_____ Date_____

The Physician Information/Consent section must be completed whenever the following conditions exist:

- Any herbal or other medication not FDA approved;
- Any OTC medication product that contains aspirin;
- An OTC medication is to be given daily for greater than 10 days;
- An OTC medication is to be given in a dosage other than the recommended therapeutic dose; or
- Any prescription medication

PHYSICIAN INFORMATION/CONSENT

Print Name of Provider_____ Clinic Name _____

Phone Number_____ Fax Number _____

Address _____

Signature of Provider_____ Date_____

Revised 5/2019