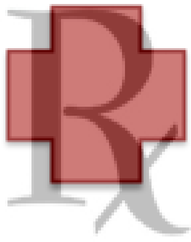
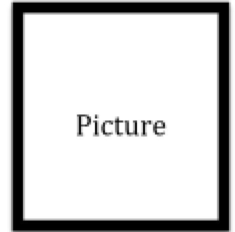


Neenah Joint School District
410 S Commercial St.
Neenah, WI 54956

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 4/2017