

**HORTONVILLE AREA SCHOOL DISTRICT  
HEALTH SERVICES  
MEDICATION ADMINISTRATION CONSENT FORM**

<ul style="list-style-type: none"> <li>▫ Greenville Elementary 920-757-7160; (Fax) 920-757-6972</li> <li>▫ Greenville Middle School 920-757-7140; (Fax) 920-757-7141</li> <li>▫ North Greenville Elementary 920-757-7030; (Fax) 920-757-7031</li> </ul>	<ul style="list-style-type: none"> <li>▫ Hortonville Elementary 920-779-7911; (Fax) 920-779-7915</li> <li>▫ Hortonville Middle School 920-779-7922; (Fax) 920-779-7923</li> <li>▫ Hortonville High School 920-779-7933; (Fax) 920-779-7935</li> </ul>
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*One form for each child and for each medication at school. New form required for changes in medication, dosage, time, etc.*

Student's Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Student's Weight: \_\_\_\_\_ lbs. Teacher: \_\_\_\_\_ Grade: \_\_\_\_\_

Medication Name/Strength: \_\_\_\_\_ Dosage (in ml, mg, etc.): \_\_\_\_\_

Route: \_\_\_\_\_ Time(s) to be given: \_\_\_\_\_ Expiration date (if listed): \_\_\_\_\_

If school has an early release, do you want the medications to be given at school? **Yes No**

Effective Date: Entire School Year **OR** Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

Reason for Medication: \_\_\_\_\_ Possible side effects: \_\_\_\_\_

**MEDICATION CONSENT:** I hereby agree to give my permission for school personnel to administer this medication to my child according to the directions stated above and to contact my child's practitioner if necessary. I further agree to hold the Hortonville Area School District, and the HASD employee(s) who is (are) administering the medication harmless in any or all claims arising from the administration of this medication at school. I agree to notify the school in writing at the termination of this request or when any change in the above orders is necessary.

Parental/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Phone: \_\_\_\_\_

**Prescribing Practitioner authorization is REQUIRED for all medications that are prescribed, non-FDA approved or in dosages that exceed the manufacturer recommendations**

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**This Section Must be Completed by the Prescribing Practitioner**

Prescribing Practitioner's Name (Please Print): \_\_\_\_\_ Date: \_\_\_\_\_

Prescribing Practitioner's Signature: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Prescription Medication Inventory Verification (to be filled out when dropping off and picking up medication)

Date	Inventory	Signature	Signature

Please note: all medications must be picked up by a parent/guardian or designated adult within 5 business days from the last day of school and/or if the child transfers or withdraws to another school. Medications for your child, which remain in the school health room, will be disposed of after the 5<sup>th</sup> business day of the commencement of school.