BRILLION PUBLIC SCHOOLS
POLICY 453.4

Medication Consent Form B
Nonprescription Medication Consent Form

This form must be completed and be on file in the school office in order for school personnel to administer any medications according to Wisconsin State Statute 118.29.

Student Name _____ Grade/Teacher _____
Name of Medication _____
Time(s) to be given _____

Reason for medication _____

Amount/Dose _____
Number of Days _____

Parent/Guardian

I hereby give my permission to school personnel designated by the school principal to give medication to my child according to the above written instructions.

I also hereby agree to give my permission to the school principal/designee to contact the child's physician.

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

I agree to notify the school in writing at the at the termination of this request or when any change in the above is necessary.

_____ Date _____
Signature of Parent/Legal Guardian

Reminder: All medication brought to school must have the following information printed on the container:

1. Child's full name
2. Name of drug and dosage
3. Time to be given
4. Physician's name and phone number

Reviewed: 5/21/07

BRILLION PUBLIC SCHOOLS
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Medication Consent Form A.
Prescription Medication Only With Physician's Order for Administration

Student _____ Date _____
Grade/Teacher _____ Date of Birth _____
Physician _____ Physician's Phone _____
Clinic/Office/Hospital _____

Physician: In order for school Personnel to administer the medication regime you have prescribed, please complete the following form.

Please feel free to contact Brillion Public Schools, 920-756-2368, should any questions arise.

Name & Dosage of Medication	**Form:** Tablet, Capsule, Pill, other:	**Number to be Taken**	**Approximate Time of Day**	**Length of Time**

Name of medication and possible side effects: _____

Please indicate if the medication above is PRN medication: _____

Conditions under which PRN medication should be given are: _____

Physician's Signature: _____ Date: _____

Parent/Guardian: Fill out this portion of this form after your child's physician has completed the top, and return this form to the school office.

I hereby give my permission to school personnel designated by the school principal to give medication to my child according to the written instructions of the physician shown above. I also hereby agree to give my permission to the school to contact the child's physician. I further agree to hold the Brillion School District and all employees harmless in any and 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 is necessary.

Parent/Guardian Signature _____ Date: _____
Phone: _____