MINOCQUA J1 SCHOOL DISTRICT

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Medication Consent Form

Student's Name: _____
Birth Date: _____ Allergies: _____ Grade: _____ School Year: _____

Over-the-Counter Medications (OTC)

Medication Name:	**Dose:**	**Route:**	**Time:**	**Duration:**	**Reason for medication:**	**Consideration:** (Side Effects)

Prescription Medications - To Be Completed by a Medical Provider

Medication Name:	**Dose:**	**Route:**	**Time:**	**Duration:**	**Reason for medication:**	**Consideration:** (Side Effects)

Medical Provider: Check here for inhalers, epinephrine such as an EpiPen/AUVI-Q, and diabetic supplies.

☐ I have instructed this student in the proper way to use his/her medication. It is my professional opinion that this student should be allowed to self-carry and use his/her medication.

Medical Provider Information

Medical Provider Name (Print): _____
Medical Provider Signature: _____
Date: _____ Phone:_____ Facility/Address:_____

Important Reminders:

- No medications will be accepted if they are not in their original packaging with label instructions, expired, or do not have a completed signed medication consent form.
- All OTC medications will be administered per manufacturers recommendations. A physician signature is only required if the OTC medication administration does not follow manufacturer's recommendations.

Parent/Guardian consent required for all medications brought to school:

• I hereby grant permission for my child to take medication at school and authorize school personnel to contact my child's medical provider as necessary. I also grant permission for staff members to be informed of my students' health concerns/medications in order for the student to receive appropriate care.
• I agree to provide the school with the medication in its original, non-expired, and properly labeled container. Parents/Guardians must bring medication to the school. I understand that a completed and signed medication consent form is required before a medication can be administered and must be renewed every school year.
• I understand that I am responsible for maintaining a sufficient quantity of the medication/supplies at the school.
• I agree to notify the school when there are changes in health concerns or a change/termination of the medication is necessary. A new medication consent form is required for any changes to medications.
• I agree to pick up any remaining medication by the last day of school (student day) or I give the school authorization to dispose of all remaining medication(s).
• I agree to release the school district and authorized school personnel, in which my child attends school, from any and all claims arising from the administration of this medication at school.
• I understand and agree to the MJ1 medication protocols and the above information.

Parent/Guardian Print:_____ Phone: _____
Parent/Guardian Signature: _____ Date: _____