School District of Fort Atkinson
Administering Medication to Students
(Please return to your child's school)

Student Name______________________________________ Physician's Name______________________

Birth date________________ Male_______ Female_____ Physician's Address____________________

School___________________ Grade__________________ _____________________________________

Teacher (if applicable)_____________________________ Physician's Phone_____________________

Parent/Guardian___________________________________ Physician's Fax_______________________

Home Phone______________Work Phone_____________

Cell Phone____

To Parent/Guardian/Physician:

The School District of Fort Atkinson is required by state statue to give prescription medication to students only with the complete directions from a physician and signed consent by parent/guardian. Medication must by supplied in the original container or packaging. For safety and liability reasons, medication received in any container other than the original will not be acceptable for staff administration. By signing this form, you release the Board of Education, its agents and employees from any and all liability which may result from taking this medication.

Start Date__________________________________ End Date____
Beginning of school year (BOSY) End of School Year (EOSY) = July 30

Medication__________________________________ Dosage___________ Frequency______________________

Medication Expiration Date (if applicable)____

Form: ☐ Tablet/Capsule ☐ Liquid ☐ Inhaler ☐ Nebulizer ☐ Injection ☐ Other__________________________

☐ For episodic/emergency events only. (Emergency medications such as: inhaler, glucagon, insulin, Epi-pen).

Student to self-administer/carry: ☐ Yes ☐ No

Time(s) to be given______________ Reason for this medication______________________________________

If given on an "as needed" basis, please describe____

Special instructions____

Side effects (expected or predictable)____

Physician's Signature____ Date___________________
(Signature required for all prescription medication and for non-prescription medication that exceeds the manufacturer's recommended dosage).

Parent/Guardian Signature____Date___________________
(Signature required for all prescription and non-prescription medication).