



Grade: _____

Williams Bay School District Non-Prescription Medication Permission and Instruction Form

Student's Full Name: _____ Date of Birth: _____

Physician's Directions: (Please print clearly)

Name of Medication: _____

Dosage/Route: _____ Times of Administration: _____

Time Medication is to be given at school: _____

Length of Administration: _____

Reason for Medication: _____

Possible Side Effects:

State the specific conditions under which contact should be made with you in regards to the condition or reactions of the student to the prescribed medication.

ALL NON-PRESCRIPTION MEDICATION MUST COME TO SCHOOL IN THE ORIGINAL CONTAINER WITH THE ORIGINAL LABEL AND THE CHILD'S NAME WRITTEN ON THE CONTAINER.

Parent/Guardian Consent:

I hereby grant permission to the Williams Bay School district to allow a designated employee to administer the above prescribed medication to my child in accordance with the Physician's directions. I further authorize them to contact the child's Physician if necessary. My signature indicates my willingness to accept direct communication from the person administering the medication

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Name: _____ Home Phone: _____

Address: _____ Work Phone: _____

ALL PRESCRIPTION MEDICATION MUST COME TO SCHOOL IN THE ORIGINAL CONTAINER WITH THE CHID'S NAME AND PHYSICIAN'S DIRECTIONS ON THE LABEL.

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| Please return form to: | Williams Bay Elementary | or: | Williams Bay Jr./Sr. High |
| | 250 Theatre Road | | 500 W. Geneva Street |
| | Williams Bay, WI 53191 | | Williams Bay, WI 53191 |
| | (262) 245-5571 | | (262) 245-6224 |
| | Fax: (262) 245-1839 | | Fax: (262) 245-5877 |

"Non-prescription medication"