Grade:_____

Williams Bay School District
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.

My signature indicates my willingness to accept direct communication from the person administering the medication.

Physician Signature:_____ Date:_____

Physician Name:_____ Phone #:_____

Address:_____ Fax:_____

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.

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.

Please return form to:

Williams Bay Elementary
250 Theatre Road
Williams Bay, WI 53191
(262) 245-5571
Fax: (262) 245-1839

or:

Williams Bay Jr./Sr. High
500 W. Geneva Street
Williams Bay, WI 53191
(262) 245-6224
Fax: (262) 245-5877

"prescription medication"