DODGELAND SCHOOL DISTRICT
OVER-THE-COUNTER MEDICATION CONSENT FORM
Fax # 920-386-4498

This order for over-the-counter medication is required to be completed and presented to the school a student attends before any over-the-counter medication may be administered to a student in accordance with section 118.29 (2)(a)(2) of state statutes, Board policy and District procedures.

Student Name _____ Grade _____

Home Address _____

Parent/Guardian Name _____

Phone Numbers (home)_____ (work) _____ (cell) _____

Reason for Medication(s) _____

Daily Medication and P.R.N. Medications (as is needed)

Medication	Dose	Route	Time(s) To Be Given	Duration (From-To)	For P.R.N. Medication - Condition Under Which Medication Should Be Given	Conditions or Adverse Reactions Requiring Parental and/or Practitioner Notification *(If none, state this)*

I agree to the following:

- I understand that my child is prohibited from carrying any over-the-counter medication per Board Policy #5330 – Administration of Medication/Emergency Care.
- I agree to give all medications to the School Nurse or designated employee.
- I understand that the District Administrator and/or Principal may authorize an employee to administer prescription medication to students and I give permission to the designated trained employee to administer the medication(s) to my child according to the directions stated above.
- ☐ *(check only if applicable)* I give approval for my child to self-administer the following medication(s)

  _____

- I will hold the Dodgeland School District, its employees and agents who act within the consent granted by this document, harmless in any and all claims arising from the administration of medication (as identified above) at school or school-related activities.

Signature of Parent/Guardian _____ Date _____

Signature of Student (age 18 or older) _____ Date _____

Revised July 2022