School District of Milton

SCHOOL MEDICATION PERMISSION AND INSTRUCTIONS
PRESCRIPTION MEDICATIONS

The School District of Milton agrees to assist with the administration of the **physician prescribed** medication for your child. The following information **must** be filled out and signed by **both the physician and the parent/guardian.**

I hereby grant permission for the School District of Milton staff to supervise the medication routine for the student named below.

Student Name _____ Birthdate _____

School _____ Grade _____ Teacher _____

Medication, dosage and instructions for the school day.

_____

I should be contacted regarding the following conditions or reactions:

_____

I am willing to accept direct communication with school personnel concerning medication issues for this student.

Physician Name _____ **Phone** _____

Physician's Signature _____ **Date** _____

Parent/Guardian Signature _____ **Date** _____

Erin Kotthaus, RN * Phone: 608-868-9571 * Fax: 608-868-9399 * kotthause@milton.k12.wi.us

School District of Milton

SCHOOL MEDICATION PERMISSION AND INSTRUCTION
NON-PRESCRIPTION MEDICATION

The School District of Milton agrees to assist with the administration of **non-prescription (over the counter)** medication. The following information must be filled out and signed by the **parent/guardian.** Non-prescription medication must be in the original container and labeled with the student's name.

I hereby grant permission for the School District of Milton staff to supervise the medication routine for the student named below.

Student Name _____ Birthdate _____

School _____ Grade _____ Teacher _____

Medication, dosage and instructions for the school day.

_____

Parent/Guardian Signature _____ **Date** _____

Self-Medicate Instructions

At the school's discretion students may self-medicate medications at school. If a student does self-medicate at school **a signed statement by the parent/guardian must be on file in the school office.**

Self-Medicate Instructions:

_____

Parent/Guardian Signature _____ **Date** _____

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