Medication Consent Form
Occasional (OTC) Medication
School District of McFarland Health Services

Conrad Elvejhem Primary School	Waubesa Intermediate School	Indian Mound Middle School	McFarland High School
Phone: 608-838-4674	Phone: 608-838-4673	Phone: 608-838-4672	Phone: 608-838-4682
Fax: 608-838-4503	Fax: 608-838-4613	Fax: 608-838-4588	Fax: 608-838-4562

STUDENT INFORMATION

Student Name _____ Grade _____ School _____

Diagnosis _____ Dose _____ Route _____

Medication name _____ Strength _____ Expiration date _____

Time of dose to be given _____ Start date _____ End date _____

AS-NEEDED (OVER-THE-COUNTER) MEDICATIONS

Please select which medications/treatments (supplied by health services) may be administered to your student. When visiting the health office, health staff has standing doctor's orders to administer the following medications/treatments to your child (as needed). The "YES" box must be checked and this form must be signed before medication can be administered.

☐ Yes	**Acetaminophen (Under age 12)** Weight-based dosing	☐ Yes	**Ibuprofen (Under age 12)** Weight-based dosing
☐ Yes	**Acetaminophen (age 12 & up)** Please select dosage: ☐ Only 1 tablet (325mg) or chewable/liquid equivalent ☐ 1 or 2 (325mg) tablets or chewable/liquid equivalent	☐ Yes	**Ibuprofen (age 12 & up)** Please select dosage: ☐ Only 1 tablet (200mg) or chewable/liquid equivalent ☐ 1 or 2 (200mg) tablets or chewable/liquid equivalent ☐ 1, 2 or 3 (200mg) tablets or chewable/liquid equivalent
☐ Yes	Allergy eye drops	☐ Yes	Diphenhydramine cream
☐ Yes	Antacid tablets (Tums)	☐ Yes	Hydrocortisone cream
☐ Yes	Bacitracin ointment	☐ Yes	Saline wash
☐ Yes	Calamine/Caladryl lotion	☐ Yes	Sunscreen
☐ Yes	Cough drops	☐ Yes	Triple antibiotic ointment
☐ Yes	Diphenhydramine		

PARENT/GUARDIAN SIGNATURE REQUIRED

- I give my permission to the designated school personnel to administer the above medication(s).
- I agree to hold the McFarland School District and the persons designated to administer the above medication harmless in any events arising from the administration of this medication.
- I agree to notify the school, in writing, of any changes in the above orders.
- I agree that these medications may also be administered on field trips, including overnight trips.
- **HOME-SUPPLIED MEDICATIONS MUST BE SENT IN MANUFACTURER'S PACKAGING AND LABELED WITH: 1. Student's name 2. Medication name & dosage 3. Time dose should be given**

Parent/guardian signature _____ Date _____

Cell phone _____ Work phone _____

School nurse signature _____