

**SHELL LAKE SCHOOL DISTRICT
HEALTH SERVICES**

271 Hwy 63 S
Shell Lake, WI 54871
Phone: 715-468-7816
Fax: 715-468-7812

ADMINISTRATION OF MEDICINE

Student Name: _____ Grade: _____ D.O.B: _____

Medication Name: _____ Prescription _____ Non-Prescription _____

Dosage: _____ Route: _____ Time: _____

Start Date: _____ Termination Date: _____

Reason: _____

Prescribing Physician Name: _____ Phone Number: _____

Physician Signature: _____ Date: _____

☐ **For Inhalers and Epi Pens Only:** Check this box if ok to carry and self administer.

Prescription Medication: requires a physician's signature and a parent signature. The pharmacy-labeled container must be supplied by the parent directly to school personnel.

Non-Prescription Medication: over the counter medication, such as Tylenol or Ibuprofen, requires a parent signature only.

All medication must be provided to school personnel by an adult in its original container

I hereby give my permission for designated school personnel to give this medication to my child according to the directions stated above and for the school nurse to contact my child's physician if necessary.

I further agree to hold the School District of Shell Lake personnel harmless in any and all claims arising from the administration of this medication, according to policy, at school.

Parent Signature: _____ Date: _____

Phone Number: _____