EAU CLAIRE AREA SCHOOL DISTRICT

MEDICATION CONSENT FORM
OVER THE COUNTER MEDICATION FORM

Name of Child/Student _____ **Birthdate**_____

School Child/Student Attends _____ **Grade**_____

Child/Student's Condition/Diagnosis_____

For this diagnosis, I give consent to the following medications: (ENTIRE school year includes summer school sessions following the current school year)**

***By ECASD policy staff may administer medications only within 30 minutes before or after the scheduled time.**

MEDICATIONS (please indicate if daily or as needed)								
Medication	**Route**	**Total Dose**	**Frequency** (scheduled or as needed)	**Duration: Check box for ENTIRE school year** **Or specify dates below**	**If as needed – give for symptoms below**	**Direct contact shall be made with me should the Child develop any of the following conditions or reactions to the medication (if none, so state)**	**Student may carry?** **Yes/No**	**Student may self-administer? Yes/No**
				From: **To:**				
				From: **To:**				
				From: **To:**				

Additional directions/instructions: _____
_____

NOTE: IF YOUR CHILD WILL BE RECEIVING MEDICATIONS DURING THE DAY AT SCHOOL, THE DESIGNATED SCHOOL PERSONNEL CAN CALL ME AT ANY TIME WITH QUESTIONS OR CONCERNS RELATED TO THE STUDENT'S CONDITION AND MEDICATIONS.

I WILL HAVE TO COMPLETE A NEW MEDICATION CONSENT FORM WHEN THERE ARE CHANGES IN THE MEDICATION OR IN THE ADMINISTRATION OF MEDICATION FOR THIS CHILD/STUDENT

I agree and accept my responsibilities regarding school administration of medication to my Child, that is, to:

1. Notify the school of my Child's needs.
2. Complete this "Medication Consent Form", which grants the school permission to administer medication to my Child in the dosage indicated. This "Medication Consent Form" is valid only for the current school year and the summer immediately following.
3. Deliver the "Medication Consent Form" and the initial supply of medication to the school.
4. Make sure that each medication is in the original manufacturer's container that lists the ingredients and recommended dose.
5. Assume full responsibility for the safe delivery of medications to appropriate school personnel.
6. Notify the school, in writing, if the medication is discontinued during the school year.
7. Hold the Eau Claire Area School District, its employees and agents who are acting within the scope of their duties, harmless in any and all claims arising from the administration of or exchange of information regarding the medications noted on the "Medication Consent Form" at school or at school-related events.

MY SIGNATURE INDICATES THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION.

Parent/Guardian Signature_____**Date**_____

Parent/Guardian Printed Name_____**Phone**_____

Parent/Guardian Address_____**Fax No.**_____