



12801 West Fairmount Avenue  
Butler, Wisconsin 53007

(262) 781-4996  
Fax: (262) 781-3512

**PARENT/ GUARDIAN MEDICATION CONSENT FORM**

*(TO BE COMPLETED BY PARENT/GUARDIAN FOR ALL MEDICATIONS TO BE GIVEN AT SCHOOL)*

(Please type or print legibly)

Name of School: \_\_\_\_\_ St. Agnes School \_\_\_\_\_

Address of School: \_\_\_\_\_ 12801 W. Fairmount Avenue, Butler, WI 53007 \_\_\_\_\_

Telephone # of School: \_\_\_\_\_ 262-781-4996 \_\_\_\_\_

Full name of child to be medicated: \_\_\_\_\_

Name of drug and dosage: \_\_\_\_\_

Hour(s) medication to be given: \_\_\_\_\_ # of days \_\_\_\_\_

Name of Physician's prescribing medication: \_\_\_\_\_

Physician's phone number: \_\_\_\_\_

***I hereby give permission to the Health Room/Office Personnel to give the medication(s) to my child according to the directions stated above and further authorize them to contact the child's physician. I agree to hold the above named school, its employees, and agents who are acting within the scope of their duties, harmless in any and all claims arising from the administration of this medication at school.***

***I agree to notify the school, in writing, at the termination of this request or when any change in the above order is necessary.***

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Address

\_\_\_\_\_  
Home Phone #

\_\_\_\_\_  
Work Phone #

Please return this form completed along with the medication(s) to the school office.

2011/2012