Merton Community School District
Medication Permission Form

This form applies to <u>ALL</u> prescription and non-prescription medications

Full name of student: _____ D.O.B. _____

Name of medication: _____

Purpose of medication: _____

Time(s) to be administered: _____

Dosage: _____

Possible side effects: _____

Termination date of administering: _____

Physician's name: _____

Physician's signature: _____
(Must have signature for prescription medication dispensation)

Physician's telephone number: _____

I hereby grant my permission as the parent/guardian of the above named student to take this medication at school with the understanding that:

1. The student will, in the presence of school-designated supervision, administer his/her medication.
2. It is the responsibility of the parent/guardian to provide all medication to the schools in the necessary quantities and intervals to assure a proper on-hand balance of meds at school.
3. **<u>All medications</u> must be presented in the original package OR prescription bottle.**
4. I have read and agree to follow the guidelines set forth in the student medication policy #453.4 and #453.4 R

Signature of parent/guardian: _____

Date: _____

Form may be brought into the School Office, Faxed to: 1-262-538-3937 Attn: Nurse Gayl or emailed to wardg@merton.k12.wi.us