BIG FOOT UNION HIGH SCHOOL DISTRICT
P:262-275-2116 F:262-275-5117

LINN JT.6 SCHOOL DISTRICT
P:262-248-4120 F:262-248-5133

WALWORTH JT. SCHOOL DISTRICT #1
P:262-275-6896 F:262-275-2272

Student Medication Administration Form

Complete one form for each medication. Physician signature is required for all prescription medication.
All medication must be provided to the school in its original container and be properly labeled.

Student Name: _____ Date of Birth: _____ Grade: _____

School: _____ Current School Year: _____ Allergies: _____

Non-Prescription (Over-the-counter) Medication

To be completed by parent/guardian

Medication Name: _____ Dose: _____ Route: _____

Reason for Medication: _____ □ Scheduled □ As Needed

Administration Instructions: _____

Prescription Medication

To be completed by physician

Medication Name: _____ Dose: _____ Route: _____

Reason for Medication: _____ □ Scheduled □ As Needed

Administration Instructions: _____

Date of Expiration: _____ Fax: _____

For Asthma Inhalers and Epi-Pens only, complete if applicable:

☐No ☐Yes – This child is both capable of and responsible for self-administering this medication

☐No ☐Yes – I recommend this child be allowed to self-carry this medication and use it as needed

Physician's Name: _____ Phone: _____

Physician's Signature: _____ Date: _____

I give permission for designated school personnel to administer the listed medication to my child, or for my child to self-administer this medication if applicable. This form shall also permit designated school personnel to share and request relevant health information regarding the administration of this medication. I am responsible for notifying the school if there is a change in the medication. I understand that medications are not always given by a licensed medical professional. This form is only valid for the current school year.

Parent/Guardian Name: _____ Phone Number: _____

Parent/Guardian Signature: _____ Date:_____

OFFICE USE ONLY:

Date medication received by health office: _____ Amount received: _____

Medication verified and counted by: _____ / _____

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Date medication returned to parent/guardian: _____ Amount returned: _____

Name and signature of person releasing medication: _____

Name and signature of person picking up medication: _____