



WITTENBERG-BIRNAMWOOD SCHOOL DISTRICT

400 WEST GRAND AVENUE – WITTENBERG – WISCONSIN – 54499



Garrett Rogowski
District Superintendent

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“HOME OF THE
CHARGERS”

MEDICATION ADMINISTRATION CONSENT FORM

Wisconsin Statute 118.29

A separate form is needed for each medication.

*Please use the school district emergency plan form **or** your health care provider emergency plan form for medications used to treat **asthma, severe allergies, or seizures.***

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

School: Birnamwood Elem & Middle School Wittenberg Elem & Middle School WB High School

Medication Name: _____ Prescription / Non-prescription

Dosage and time: _____

Route: Oral Topical Other Dates Effective: _____ to _____
(Please note a new form is needed each school year)

Reason for medication: _____

For an “as needed (PRN)” medication, please list specific conditions under which medication should be given:

State the side effects for which we should contact you: _____

Licensed Health Care Provider Name, address and phone:

Signature of Health Care Provider (prescription only)

Date Signed

A health care provider’s written, signed statement and pharmacy labeled container must be supplied by the parent/guardian if prescribed medication is to be given at school. Over-the-counter medication must be provided to the school in the original container.

I hereby give permission for designated school staff to give this medication to my child according to the directions stated above and for the school nurse to contact my child’s physician as necessary. *I further agree to hold harmless the Wittenberg-Birnamwood School District, its Board of Education, administration, and all employees and agents who are acting within the scope of their duties, harmless 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 Signed