

**SCHOOL DISTRICT OF HARTFORD Jt. #1**  
**NON-PRESCRIPTION MEDICATION**  
**PERMISSION FORM**

Use a separate form for each medication.

**All medication must be brought in by the parent/guardian in its current container with label intact.**

Central Middle School  
 1100 Cedar Street  
 Hartford, WI 53027  
 Phone: 262-673-8040  
 Fax: 262-673-7596

Lincoln Elementary School  
 755 S. Rural Street  
 Hartford, WI 53027  
 Phone: 262-673-2100  
 Fax: 262-673-0148

Rossmann Elementary School  
 600 Highland Avenue  
 Hartford, WI 53027  
 Phone: 262-673-3300  
 Fax: 262-673-3543

Date form received by the school: \_\_\_\_\_

Student: \_\_\_\_\_ D.O.B./Age: \_\_\_\_\_

Grade: \_\_\_\_\_ Teacher/Classroom: \_\_\_\_\_

Principal's Signature: \_\_\_\_\_

**To be completed by the parent or authorized guardian**

Name of medication: \_\_\_\_\_

Reason for medication: \_\_\_\_\_

Form of medication/treatment: \_\_\_\_\_



Tablet/Capsule



Liquid



Cough  
Suppressants



Topical  
Antibiotics



Decongestants



Other

Instructions (schedule and **exact** dose to be given at school): \_\_\_\_\_

Start date: \_\_\_\_\_

Stop date: \_\_\_\_\_

Restrictions and/or important side effects: ☐ None anticipated ☐ Yes. Please describe: \_\_\_\_\_

Special storage requirements: ☐ None ☐ Refrigerate ☐ Other \_\_\_\_\_

**PARENT/GUARDIAN CONSENT FORM**

I hereby give permission for (print name of child) \_\_\_\_\_ to receive medication at school according to School District Policy JHCD. I also authorize the District designated personnel to give medication(s) to my child according to the directions stated above. I agree to hold the School District of Hartford Jt. #1, its employees and agents who are acting within the scope of their duties harmless (Wisconsin Statutes 118.29). I also agree to notify the school in writing in the event that any change(s) in the administration of this medicine occur.

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Name \_\_\_\_\_

| INITIALS AND SIGNATURE OF PERSON GIVING MEDICATION |           | INITIALS AND SIGNATURE OF PERSON GIVING MEDICATION |           | KEY                 |                   |
|--|-----------|--|-----------|---------------------|-------------------|
| INITIALS   | SIGNATURE | INITIALS   | SIGNATURE | A – Absent          | W – Dose withheld |
|  |           |  |           | D – Early dismissal | X – Out of meds   |
|  |           |  |           | F – Field trip      |                   |
|  |           |  |           | O – Other           |                   |
|  |           |  |           | R – Refuse to take  |                   |

[illegible]