Winneconne Community School District
Consent for Administration of Stock Medication at School

Student: _____ Date of birth: _____ Grade: _____

As a courtesy to our parents/guardians, we offer Stock (over the counter medication) to our Middle School and High School students ONLY during the school day with parent/guardian consent. This form is **OPTIONAL**, and can be changed at any time by notifying the health office.

***Please indicate if you would like Stock medication available "as needed" for your child during the school day?** Y/N

If yes, please indicate dosage (quantity) of the medication you would like available to your child. **In addition, medications will ONLY be administered as directed on the manufacturing label and will be in tablet form.**

Medication	Reason for use
Acetaminophen (Tylenol) ❒ 1 tablet = 325 mg ❒ 2 tablets = 650 mg	Pain Relief
Extra Strength Acetaminophen (ES Tylenol) ❒ 1 tablet = 500 mg ❒ 2 tablets = 1,000 mg	Pain Relief
Ibuprofen (Advil) ❒ 1 tablet = 200 mg ❒ 2 tablets = 400 mg	Pain Relief
Pepto Bismol ❒ 2 tablets = 262 mg	Stomach/nausea Relief
Claritin (Loratadine) ❒ 1 tablet = 10 mg	Allergy Relief
Zyrtec (Cetirizine) ❒ 1 tablet = 10 mg	Allergy Relief
*Benadryl (Diphenhydramine) ❒ 1 tablet = 25 mg ❒ 2 tablets = 50 mg	Allergy Relief

** = Family will be consulted prior to administration of this medication and due to the potential side effects, administration of this medication will result in the child going home.*

Please list any other reasons not listed above for the use of any of these medications (list medication and reason) if applicable: _____
_____

Parent/Guardian Authorization

Please review the following:

- **I certify my child has no known allergies to the above checked medications.**
- I give authorization to the designated school district personnel to administer the medication(s) I have selected for my child during the school day.
- I give permission to the designated school district personnel to notify other appropriate school district personnel and classroom teachers of medication administration and possible adverse effects of the medication.
- I further agree to hold the WCSD employee(s) who is (are) administering the medication harmless in any or all claims arising from the administration of this medication at school.

As the parent/guardian of this child, I acknowledge that by signing below, I am agreeing to the information above.

Parent Name: _____

Parent Signature: _____ Date: _____

Revised: 08/23