West Allis West Milwaukee School District – 1205 South 70th Street, West Allis, WI 53214 – 414-604-3000

Medication Self Administration
Parent Consent

School Name: _____

Student Name: _____ Date of Birth: _____

I hereby give permission for my child to self administer the below listed medication.Please use one sheet per medication.

Medication Name: _____

Prescription: _____ Non-prescription: _____

Dosage: _____ Frequency/Administration Time: _____

Route: _____

I accept complete responsibility for my child's medication self administration and release the school district from any and all liability. I understand that my child will be held responsible for the proper use of any medications carried on his/her person for self administration purposes. Appropriate disciplinary action will take place if any medication is transferred to another student by my child.

Parent/Guardian Initials: _____

I understand that I cannot provide my child with more than a one day supply or one dispensation unit of said medication on a daily basis.

Parent/Guardian Initials: _____

Parent Signature: _____ Date: _____

Student Signature: _____ Date: _____

(required for students age 14 yrs. and older)

Note: This form may be faxed to the respective school upon completion or to the District Nursing Department at 414-546-5641. For questions call the District Nursing Department at 414-604- 4000 x 1107.