HEALTH SERVICES
Administration of Medication Consent

*Physician Statement**

One form for each medication given at school

Student Name: _____ Date of Birth: _____

Campus: _____ Grade/Room:

Medication Name**/Strength: _____

Dosage**: _____ Route**: _____ Frequency: _____

Starting Date: _____ Termination Date: _____

Reason for Medication: _____

_____

_____

_____

Precautions, possible untoward reactions, and/or interventions: _____

_____

_____

Prescribing physician name: _____

Phone: _____ FAX: _____

Address: _____

Signature of Physician: _____ Date: _____

ST. FRANCIS XAVIER Catholic School System

101 E Northland Ave
Appleton, WI 54911
920-735-9380

*Form to be **completed by R.N. or M.D. and signed by M.D.** – one medication per form.
**A new physician statement will be needed for any changes in medication, dosage, route, or frequency.