



Call us toll-free at 866-SEIZNET (734-9638)  
www.wisconsinseizure.net

## Medicine Consent Form

Name of student: \_\_\_\_\_

Name of school: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: (H) \_\_\_\_\_ Phone: (W) \_\_\_\_\_

Name of medicine: \_\_\_\_\_

Reason for medicine: \_\_\_\_\_

Dosage: \_\_\_\_\_ Route: \_\_\_\_\_ Time: \_\_\_\_\_

Any special way to give medicine: \_\_\_\_\_

Possible side effects: \_\_\_\_\_

Any particular side effect to watch for: \_\_\_\_\_

What to do if child misses a dose: \_\_\_\_\_

Prescribing physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Clinic nurse: \_\_\_\_\_ Phone: \_\_\_\_\_

I agree to notify the school in writing at the termination of this request or when any change in the above medication is necessary. I authorize the school as above to administer the medication as ordered at the designated time.

**Parent's signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**The above orders shall be effective through \_\_\_\_\_ unless discontinued or changed by the provider.**

**Provider's signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_