Hustisford School District

District Office
845 S. Lake St. · P.O. Box 326
Hustisford, WI 53034
(920) 349-8109

Todd Bugnacki
District Administrator

Corey Manlick
Director of Financial Services

Jr./Sr. High School
845 S. Lake St. · P.O. Box 326
Hustisford, WI 53034
(920) 349-3261

Clint Bushey
Principal

Alex Pishler
Director of Special Education/Psychologist

John Hustis Elementary
600 S. Hustis. St · P.O. Box 326
Hustisford, WI 53034
(920) 349-3228

Peter Moe
Principal

Glen Falkenthal
Athletic Director

Hustisford School District Authorization to Administer Medication

HIgh School Fax: 920-349-8495 Elementary School Fax: 920-349-3530

Student Name: _____ Date of Birth:_____ Grade: ____ Allergies: _____

I give permission for my son/daughter to receive the following prescription/FDA approved over the counter medication during school hours and during school sponsored activities/field trips that occur after hours. I will be responsible for:

1. Delivery of medication in a pharmacy labeled/original manufacturer's container to the school office
2. Maintaining a sufficient supply of medication
3. Keeping school personnel informed of changes in the medication (dosage,time)
4. Obtaining a new form from the prescribing physician for any changes in this medication

I hereby release the board of Education and its agents and employees from any and all liability that may result from my child taking the prescribed medication.I understand the above information may be shared with necessary school personnel. The physician order/parental consent above shall remain in effect through the end of the current school year unless discontinued/ changed by the provider or parent/guardian withdraws the request in writing. In addition, I give my permission for school health staff to discuss this medication with the prescribing provider if needed. My signature indicates I have read and understand the above information.

Name of Medication: _____ Dose: _____ Time:_____(Exact time or as needed)

Route: ☐ Oral ☐ Other _____ **Given for: _____**

AT THE END OF THE SCHOOL YEAR, PLEASE (circle one):

Contact me to pick up remaining medication	Dispose of remaining medication	Send remaining medication home with student

Prescribing Provider: _____ Phone Number: _____

Parent Signature_____ Date_____

TO BE COMPLETED BY THE PROVIDER (for prescription medication only): *The above medication is to be administered in accordance with the written instructions/agreements.I understand non-medically trained school personnel may give medication. I authorize school district employees to contact myself with questions regarding the medication administration including clarification regarding dosage, side effects or indication of the medications listed above. Please contact me if:_____.*

Reviewed 4/2025

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Provider Signature_____ **Date:** _____