



# School District of New London

## DISTRICT ADMINISTRATION OFFICE

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New London, WI 54961 Fax (920) 982-8551

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Parkview Elementary 920-982-8538  
920-982-8700 (FAX)  
Readfield Elementary 920-667-4265  
920-667-4295 (FAX)  
New London High School 920-982-8420  
920-982-8449 (FAX)  
Board of Education Office 920-982-8530  
920-982-8551 (FAX)

Lincoln Elementary 920-982-8540  
920-982-8701 (FAX)  
Sugar Bush Elementary 715-752-4135  
715-752-4010 (FAX)  
New London Middle School 920-982-8602  
920-982-8605 (FAX)  
Catalyst Academy 920-982-8686  
920-982-8689 (FAX)

### ADMINISTRATION OF MEDICATION CONSENT

\*\* A separate form is needed for each medication and a new form is required annually.

**Student Name:** \_\_\_\_\_ **Grade:** \_\_\_\_\_ **D.O.B.:** \_\_\_\_\_

**School:**  Parkview  Readfield  Lincoln  Sugar Bush  Intermediate/Middle School  High School  Catalyst

**Medication Name:** \_\_\_\_\_  Prescription  Non-Prescription

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

**Starting Date:** \_\_\_\_\_ **Termination Date:** \_\_\_\_\_

**Reason for Medication:** \_\_\_\_\_

If "as necessary," conditions under which medication should be given: \_\_\_\_\_

**Precautions, possible unfavorable reactions, and/or interventions:** \_\_\_\_\_

**Health Care Provider Name (please print):** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Doctors Fax # :** \_\_\_\_\_

**Health Care Provider Signature:** \_\_\_\_\_

(Health Care Provider signature is required annually for all prescription medications)

I hereby give my permission for designated school personnel to give this medication to my child according to the directions stated above and for the school nurse to contact my child's physician if necessary.

**A physician's written, signed statement and pharmacy-labeled container must be supplied by the parent/guardian if prescribed medicine is to be given during the school day. Over-the-counter medication must be provided to school personnel in its original container.**

I further agree to hold the School District of New London and above persons harmless in any and all claims arising from the administration of this medication, according to policy, at school. I agree to notify the school in writing when any change in the above orders is necessary.

**Home Phone:** ( ) \_\_\_\_\_ **Cell Phone:** ( ) \_\_\_\_\_ **Work Phone:**( ) \_\_\_\_\_

**Signature of Parent:** \_\_\_\_\_ **Date:** \_\_\_\_\_