La Crosse County
Human Services Department
300 North Fourth Street
P.O. Box 4002
La Crosse, WI 54602-4002

CONSENT FOR MEDICATION DISPERSAL AND EMERGENCY MEDICAL TREATMENT

Western Regional Adolescent Center

I, _____as the parent /guardian/custodian
(Name)

of _____hereby authorize the Western Regional
(Name of resident)

Adolescent Center and its staff and medical/nursing vendor to dispense my sons/daughters prescription medication to Him / Her.

I, also give my permission to provide emergency medical care if the need arises. This includes the issuance of over the counter medication if asked for by your son or daughter.

_____
(Signature)

_____
(Date)

Please indicate any exceptions to this consent, including any non-prescription medication your child should not be allowed to take.

_____
_____
_____
_____
_____

Please Note: The Western Regional Adolescent Center will only dispense medication that is brought in the original prescription bottle. It is the responsibility of the parent / guardian to make sure that all medications are provided to program staff and that enough medication is provided to last though your child's program requirements. The Western Regional Adolescent Center is not responsible for refilling prescriptions. This consent is valid for 6 months from the date of signature.