Medication Request/Consent Form

Mauston School District, Mauston, Wisconsin

Medications are to be administered at home whenever possible. If it is necessary for a student to receive medications at school, all appropriate portions of this form must be completed before medication can be given at school. One form for EACH medication is required.

Name of Student: _____ School: _____ Grade: _____

Address: _____ Phone: _____ Birthdate: _____

Physician Name: _____ Address: _____ Phone: _____

MEDICATION/PROCEDURE:

Name of Medication or Procedure: _____

Reason for medication/procedure (diagnosis): _____

Directions: (Write all directions as they appear on bottle label.) _____

_____

Time to be given at school: _____ Dose at School: _____

Dates to be given: From: _____ To: _____

If medication is to be given on an as needed basis (PRN), state conditions under which medication is to be given: _____

_____ How soon can administration of medication be repeated? _____

Precautions/Unfavorable Reactions: _____

PARENT/GUARDIAN CONSENT: (complete for all Medication/Procedures at school)

- I request and authorize that school personnel administer this medication at school.
- I will supply medication in its original, updated, properly labeled container. (Request extra bottle from pharmacist.)
- This order is in effect for this school year unless otherwise indicated.
- I will obtain a new health care provider's order and notify the school in writing for any changes.
- I authorize school personnel to exchange information verbally or in writing with my child's physician regarding this
  - medication or the conditions for which it is prescribed.
- I further understand that all medication is to be transported to and from school by parent/guardian.
- I understand that non-medically trained school personnel will give medication
- I agree to hold the School District, its employees and agents who are acting within the scope of their duties harmless
- in any and all claims arising from the administration of this medication at school.
- My signature indicates that I have fully read and understand the above information.
- **ASTHMA INHALERS AND EPI PENS ONLY**: This student is capable of self-administration and may carry inhaler or EPI pen and self-administer in school. ☐ Yes ☐ No
- **HIGH SCHOOL STUDENTS ONLY:** This student is capable of self-administration and may carry and self-administer the above over-the counter medication in school ONLY. Medications may NOT be shared with or distributed to other students. On Field Trips or other School Sponsored Events off campus, over the counter medication and the self-administration of the medication will be managed by a designated adult in charge. Students will not be permitted to carry over the counter medication on school sponsored or field trips. ☐ Yes ☐ No

_____ _____ _____

Signature of Parent/Legal Guardian Date Telephone Number

_____ _____

Signature of Student **Date**

PHYSICIAN ORDER: (required for all Prescription Medication/Procedures)

The above medication is to be administered during the school day in accordance with the above instructions and agreements. I agree to accept communication about student/medication and understand that non-medically trained school personnel will give the medication. Please contact me if the following symptoms occur: _____

_____

ASTHMA INHALERS AND EPI PENS ONLY: This student and his/her parents/guardians have been instructed in self-administration and student may carry inhaler or EPI pen and self-administer in school. ☐ Yes ☐ No

_____ _____ _____

Health Care Provider's Signature Date Printed Name Address and Phone Number of Health Care Provider