MEDICATION CONSENT FORM

Wisconsin Heights School District

Medications are to be administered at home whenever possible. All appropriate portions of this form must be completed before medication and/or a procedure can be administered at school. **One form for <u>EACH</u> medication or procedure is required.**

---To Be Completed by Parent---

STUDENT: _____ BIRTHDATE: ____/____/____ GRADE: _____

ADDRESS: _____ PHONE: _____/_____/_____

MEDICATION / PROCEDURE: Physician name and phone number: _____

Name of medication or procedure needed: _____

Diagnosis or purpose: _____

Time to be given at school: _____ Or, if it is as needed, how soon may it be repeated: _____

Dates to be given at school: From (Month/Day/Year): _____ To (Month/Day/Year): _____

Dose at School: _____ <u>Route</u>: Mouth _____ Inhaled _____
Injected _____ Other (Explain) _____

Directions on package label: _____

Precautions/Side Effects of concern: _____

<u>PARENT/GUARDIAN CONSENT:</u> <u>Please review each item before signing</u>

- **I understand that all medication should be delivered to and picked up from the school by a parent or guardian unless the physician indicates self-administer/ self-carry below.**
- I request and authorize that school personnel administer this medication or procedure at school.
- I will supply medication in its original, dated, properly labeled container. (Request extra bottle from Pharmacist if necessary.)
- This order is in effect for this school year unless otherwise indicated.
- I will obtain a new physician's order and notify the school in writing of any changes.
- I authorize school medical personnel to exchange information verbally or in writing with my child's physician regarding this medication or the conditions for which it is prescribed. This information will be kept for 7 years beyond the child's enrollment end date.
- I will allow my child's photo to be displayed on this form. (Please consider for emergency medications.) **YES _____ NO _____**
- I understand that non-medical, trained school personnel will administer medication/procedure.
- 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.
- For any age student-ASTHMA INHALERS and EPI PENS ONLY: This student is capable of self-administration and may carry inhaler or EPI Pen and self-administer at school. **YES ☐ NO ☐**
- Wisconsin Heights **HIGH SCHOOL STUDENT** NON CONTROLLED SUBSTANCES ONLY: This student is capable of self-administration and may carry any non-controlled substances and self-administer at school. **YES ☐ NO ☐**
  (REQUIRES practitioner's signature and agreement too.)

_____ _____/_____/_____ _____/_____/_____ _____/_____/_____
Signature of Parent/Legal Guardian ***Home Phone or Cell*** ***Business Phone*** ***Date***

PRACTITIONER'S ORDER: (Please complete for each medication/procedure)

The above medication/procedure is to be administered during the school day in accordance with the above instructions and agreements. I agree to accept communication about student's medication/procedure and understand non-medical, trained school personnel will administer the medication/procedure. Contact me if the following symptoms occur:

_____

For any age student-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 at school. **YES ☐ NO ☐**

Wisconsin Heights **HIGH SCHOOL STUDENT** NON-CONTROLLED SUBSTANCES ONLY: This student and his/her parents/guardians have been instructed in self-administration and student may carry any non-controlled substances and self-administer at school. **YES ☐ NO ☐**

_____ _____/_____/_____ _____-_____-_____
Practitioner's Signature *Date* *Phone*

_____ _____ _____-_____-_____
Print Name *Clinic Name and Address* *Clinic FAX#*