MEDICATION REQUEST/CONSENT FORM

School District of Reedsburg

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 is required for EACH medication.

STUDENT: ____________ School: ____________ Grade: ____________

Address: ____________ Phone: ____________ Birthdate: ____________

Physician Name: ____________ Address: ____________ Phone: ____________

MEDICATION/PROCEDURE:

Name of medication or procedure: ____________

Reason for medication/procedure (diagnosis): ____________

Time(s) to be given at school: ____________

Route: By mouth ____________
Injected ____________
Inhaled ____________
Other route ____________

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 PRN medication be repeated? ____________

Any additional directions: ____________

Precautions/Unfavorable Reactions: ____________

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

- I request and authorize that this medication be administered at school by school personnel.
- 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 physician's order and notify the school in writing of 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 should be delivered to the school by parent/guardian/responsible adult.
- I give my permission to have my child's photo displayed on this form. Yes ____________ No ________
- I understand that medication will be given by non-medically trained school personnel.
- 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 at school. Yes ____________ No _____

____________ ____________ / ____________ ____________

Signature of parent/legal guardian | Home Phone | Business Phone | Date

PHYSICIAN ORDER: (complete for all prescription medication and all procedures)

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

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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 ________

____________ ____________ ____________ ____________

Physician's Signature | Date | Printed Name & Address of Physician | Phone

Revised 5/08