

# 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 \_\_\_\_\_

Dose at School: \_\_\_\_\_ Injected \_\_\_\_\_

Dates to be given: From: \_\_\_\_\_ To: \_\_\_\_\_ Inhaled \_\_\_\_\_

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: \_\_\_\_\_

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