SCHOOL DISTRICT OF REEDSBURG

MEDICATION REQUEST CONSENT FORM

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. **ONE FORM is required for EACH MEDICATION.**

STUDENT: _____ **DOB:** _____ **SCHOOL/GRADE:** _____

MEDICATION

Name of Medication: _____
Reason for Medication: _____
Dose: _____
Route: Check one: Orally ____ Inhaled ____ Injected _____ G-Tube ___ Other ___ If other, please specify _____
Time(s) to be Given: _____
Dates to be Given: From: _____ To: _____ /All School Year: _____

If medication is to be given as needed/PRN, state conditions when medication is to be given: _____

_____

State when administration of PRN medication can be repeated: _____
Any additional directions, precautions, or side effects: _____

PARENT/GUARDIAN CONSENT

- I request and authorize that this medication be administered at school by non-medically trained school personnel.
- I will supply medication in its original, updated, properly labeled container.
- This order is in effect for this school year unless otherwise indicated.
- I will obtain a new 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 healthcare provider regarding this medication or the conditions for which it is prescribed.
- I understand that all medication should be delivered to the school by a parent/guardian/responsible adult.
- I agree to release the School District of Reedsburg and its employees and agents who are acting within the scope of their duties from any and all liability that may result from my child taking this medication at school.
- My signature indicates that I have fully read and understand the above information.
- ASTHMA INHALERS AND EPIPENS: My child is capable of self-administration and may carry their inhaler or EpiPen and self-administer at school. Yes:___No:___ *In the event that a child is using their inhaler or EpiPen inappropriately, for safety reasons, the school nurse can revoke this permission, and medication will be kept in the office.

_____ _____ _____
Signature of Parent/Guardian **Phone** **Date**

HEALTH CARE PROVIDER ORDER (complete for all PRESCRIPTION medication)

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

ASTHMA INHALERS AND EPIPENS: This student and their parents/guardians have been instructed in self-administration and may carry their inhaler or EpiPen and self-administer at school. Yes:___No:___

_____ _____
Health Care Provider Signature **Date**

_____ _____
Printed Name & Address of Health Care Provider **Phone**

Reviewed by School RN
Initials:_____Date:_____