Medication Request/Consent Form

Baraboo School District, Baraboo, 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 physician'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
- Please provide two Epi pens or inhalers: one for classroom or on person and one for designated medication storage area at school.

____________________ ____________ / ____________ ____________
Signature of Parent/Legal Guardian | Telephone Home | Business | 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

____________________ ____________ ____________________
Physician's Signature | Date | Printed Name and Address of Physician /Phone Number