SUN PRAIRIE AREA SCHOOL DISTRICT
501 South Bird Street
Sun Prairie, WI 53590

PRESCRIPTION
MEDICATION ADMINISTRATION CONSENT FORM
(Please print clearly)

Student name: _____ Parent/Guardian name: _____
Phone #: _____ School: _____ Grade: _____ Date of Birth: _____

PRACTITIONER SECTION

Practitioner name: _____ Phone #: _____

Diagnosis: _____

Name of medication & strength (e.g., mg.): _____ Time to be given: _____

Dose & route of administration: _____ How often _____

Reason for medication: _____

Considerations/side effects _____

Duration: From _____ to _____

For an as-needed (PRN) medication, state specific conditions under which medication is to be given:

State the side effects for which we should contact you:

NOTE: Your signature on this document attests to your willingness and intent to direct, supervise, decide, inspect and oversee the administration of the medication by non-medically trained designee(s) and that you will accept direct communications from them regarding the administration of the medication. We urge that all instructions be stated in language of the lay person. Any changes to this order must be in written form.

_____ _____
Practitioner's Signature Date

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PARENT/LEGAL GUARDIAN SECTION

I hereby give my permission to the Sun Prairie Area School District to administer medication to my child according to the directions stated above and further authorize them to contact the child's practitioner if warranted (should the need arise for the safety of my child and other students).

I will notify the school in writing whenever this consent is withdrawn prior to the end of the duration period stated above.

_____ _____
Signature of Parent/Legal Guardian Date

NOTE: Medications must be brought to school in the original container labeled with the student's name.

JHCD-F(1) (Maintained by Administration)
Adopted by the School Board: October 1995
Revised by the School Board: October 1998
Delegated to Administration: January 11, 1999
Updated: February 25, 2003, February 29, 2012