

**Waunakee Community School District  
PRESCRIPTION MEDICATION CONSENT FORM  
(Each medication requires a separate form)**

**TO BE COMPLETED BY THE LICENSED PRACTITIONER:**

Student Name	DOB
School	Grade
Diagnosis	Medication
Dose	Frequency/Times
Start Date	Stop Date
Possible Side Effects	

**LICENSED PRACTITIONER CHECK ONE:**

**Prescription Medication Administered By Authorized School Personnel**

- Authorized school personnel will administer this prescription medication. As the licensed practitioner, I will direct administration and am willing to accept communication from authorized school personnel.

**Prescription Medication Is To Be Self-Administered By The Student**

- This prescription medication will be self-administered. I have instructed the student in the proper method of administration (storage of medication, dosage, date(s) and time(s) to be administered, and possible side effects). In my professional opinion, this student is able to carry and self-administer the medication independently. I understand the school district does not accept any responsibility for the self-administration of prescription medication, including, but not limited to, the administration, supervision, or documentation thereof.

Licensed Practitioner's Signature	Date
Telephone	Fax

**PARENT/GUARDIAN CHECK ONE:**

**Prescription Medication Administered By Authorized School Personnel**

- I give my permission to authorized school personnel to administer to my child the prescription medication listed above according to the licensed practitioner's directions provided on this form. I agree to hold the Waunakee Community School District and authorized staff harmless in any events arising from the administration of this medication. I agree to notify the school in writing of any changes in the above order.

**Prescription Medication Is To Be Self-Administered By The Student**

- This prescription medication will be self-administered. I have reviewed the proper method of administration (storage of medication, dosage, date(s) and time(s) to be taken, and possible side effects) with my child. I request that my child be able to carry and self-administer this medication independently. I understand the school district does not accept any responsibility for the self-administration of prescription medication, including, but not limited to, the administration, supervision, or documentation thereof.

Parent/Guardian Signature	Date
Telephone (home)	Telephone (work)

***Both parent/guardian and licensed practitioner are required to sign for prescription medications.***

***Authorized school personnel must document medication they administer on the Medication record/flow sheet.***