MEDICATION REQUEST AND AUTHORIZATION FORM

School District of Wisconsin Dells, Wisconsin Dells, WI

One form is required for **EACH** medication. Medications are to be given 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. Parents may administer needed medications to their child at school until requirements are met.

Student: _____ **Address**: _____

School: _____ **Grade**:_____ **DOB**:_____

Name of Physician or Advanced Practice Provider (APP): _____

Clinic: _____ **Address**:_____

MEDICATION/PROCEDURE **EFFECTIVE DATE:** _____ to_____

Name of Medication: _____

Dose:_____**Instructions (on label):** _____

Reason for medication/procedure (Diagnosis): _____

Time(s) to be given at school: _____

Route: Oral (by mouth) _____ Inhaled _____ Ear _____

Topical (on skin) _____ Nasal _____ Eye _____

Injection (specify SQ or IM) _____ Other: _____

If medication is to be given on an as needed basis (PRN), state the conditions under which medication is to be given:

_____

PARENT/GUARDIAN CONSENT: Complete for each Medication and/or Procedure

1. I request and authorize that this medication/ procedure be administered at school by non-medically trained school personnel.
2. 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/procedure at school.
3. I agree that a parent/guardian/responsible adult will deliver the medication to the school office in its original, properly labeled container. (Request extra bottle from the Pharmacist)
4. I will obtain a new Physician's order and notify the school in writing for any changes.
5. I authorize school personnel to exchange information verbally or in writing with my child's Physician regarding this medication/procedure or the conditions for which it is prescribed.
6. ASTHMA INHALERS & EPINEPHRINE Auto-Injecting ONLY: This student is capable of self-administration and may carry and self-administer in school. ____ **Yes** ____ **No**
7. HIGH SCHOOL STUDENTS ONLY: This student is capable of self-administration and may carry and self-administer the above **over-the-counter** medication in school. ____ **Yes** ____ **No**
8. My signature indicates that I have fully read and understand the above information.

_____ _____ _____

Signature of Parent/Legal Guardian **Date:** **Phone Number**

PHYSICIAN ORDER: Complete for each Medication and/or Procedure

ASTHMA INHALERS & EPINEPHRINE Auto-Injecting ONLY: This student and parent/guardian have been instructed in self-administration and this student may carry and self-administer in school. ____ **Yes** ____ **No**

The above medication/procedure is to be administered in accordance with the above instructions and agreements. I agree to exchange information verbally or in writing with school personnel regarding this medication or the conditions for which it is prescribed. I understand medication will be given by non-medically trained school personnel.

Please contact me if the following symptoms occur: _____

_____ _____

Name of Physician or APP (Please print) **Clinic Phone Number**

_____ _____

Signature of Physician or APP **Date**