Milwaukee Jewish Day School
6401 N Santa Monica Blvd
Milwaukee, WI 53217
Fax 414-963-272

STUDENT NAME:_____DATE OF BIRTH:_____

MEDICATION	REASON NEEDED	DOSAGE	ROUTE	FREQUENCY

- Guardian must complete this form for all prescription medications. No prescription medication will be administered without **written** consent. Email or verbal authorization will not be accepted.
- Forms listing prescription medication **must be signed by a licensed prescriber**.
- Prescription medications must be sent in the **original package**, prescription label matching instructions from the prescriber.
- New forms and medication must be provided every year. Medications are not stored anywhere in the school over the summer. All medication not picked up by the last day of school will be disposed of.
- New forms must be provided if there is any change to the medication. (i.e.: dose, time it's given, etc.)

I hereby release Milwaukee Jewish Day School and its employees from any and all liability that may result from my child taking the above medication(s). I will be responsible for bringing the prescription medication to school in a labeled container from the pharmacist. I also understand that I am responsible for maintaining a sufficient quantity of the medication or supplies at the school. Failure to do this will result in an interruption of the physician's order or discontinuation of the school's administration of the medication/procedure for my child. I understand that, if my child refuses to take the prescribed medication(s) or allow the procedure(s), force will not be used by school personnel to make my child comply. School personnel have permission to communicate with the prescribing medical provider regarding use, side effects, response, and contraindications of the medication(s) or the procedure results or frequency. I can rescind my permission at any time. Additionally, I understand and agree with the information stated above.

Guardian Signature: _____ Date:_____
Phone Number: _____

The student listed above has one or more of the following **emergency/rescue medications**: (Please circle)
All grades must provide a back-up inhaler /Epi-pen/rescue seizure medication to be kept in the school office.
Children in jr. kindergarten-fourth grades will use inhalers under adult supervision.

Asthma Inhaler **Epi-pen** **Glucagon Injection** **Rescue Seizure Medications**

The student may self-carry and self-administer their emergency Asthma Inhaler: YES/NO
If yes, complete the Asthma Action Plan.

The student may self-carry and self-administer their emergency Epi-Pen: YES/NO
If yes, complete the FARE form.

If your student requires rescue seizure medications, complete the SAP form.

Any additional information/special accommodations regarding the medication listed:
_____
_____
_____

Physician Name: _____ Phone Number: _____

Physician Signature **(required):** _____ Date: _____