



Wausau School District Medication Consent for Overnight Field Trips Grade 6-12

State medication law requires written permission from the parent and medical practitioner for a student to take any prescription medications. All over-the-counter (OTC) medications given by school staff must have written permission from the parent/guardian. A practitioner's signature is not required for OTC medication *provided* the dose is within the manufacturer's guidelines. Parent and practitioner's signatures are required to self-carry any type of medication.

It is understood that:

1. All medications must be in an **original over-the-counter (OTC) or pharmacy container** with student's name, name of medication, dose and time of administration on the label and/or container.
2. Emergency self-carry medications should be with the student at all times.
3. **EMS will be called any time an emergency medication (other than an inhaler, if the student is stable) is used.**

Student's Full Name: _____ Date of Birth: _____
 School: _____ Grade: _____
 Parent/guardian Name: _____ Phone: _____
 Medical diagnosis(es): _____

MEDICATION INSTRUCTIONS

Medication Name	Dosage	Time(s) given	Specific instructions

Medication order effective from _____ until _____ (duration of trip)

Permission to Self-Carry Medication

The above listed student understands the correct use, dose, and time to take the above listed medication(s) and has parent/guardian and practitioner permission to self-carry and self-administer the medication(s). **Yes** **No**

PARENT/GUARDIAN: I hereby give permission to staff designated by the school principal or nurse to give the above education to my student according to the instructions stated above and authorize them to contact the practitioner, if necessary.

Parent/Guardian Signature: _____ **Date:** _____

PRACTITIONER: Practitioner's signature directs the above medication administration and indicates willingness to communicate with school staff regarding this medication.

Practitioner Signature: _____ **Date:** _____

Practitioner Name: _____ **Phone:** _____

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