MEDICATION CONSENT FORM

NURSE Fax number **920-492-2999**

Per Ashwaubenon School District Policy #5330. Medication should be given at home whenever possible. The administration of medication to a student during school hours will be permitted only when failure to do so would jeopardize the health of the student, the student would not be able to attend school if the medication were not administered during school hours, or the child is disabled and requires medication to benefit from his/her educational program.

Student :	**Date of Birth:**	**School:**
Physician:	**Phone:**	**Grade:**

Medication or Procedure:	**Dose:**
Start Date: **End Date:**	[ ] Daily or [ ] As needed
Route: (check box) [ ] oral [ ] inhaled [ ] nebulizer [ ] injectable [ ] topical [ ] eye [ ] ear [ ] other: _____	**Time to be given:**
If medication is (PRN), state conditions under which medication should be given:	How often:
ASTHMA INHALERS AND EPI PENS ONLY: This student is capable of self-administration and may carry an inhaler or EPI pen and self-administration in school.	[ ] Yes [ ] No

PARENT/GUARDIAN CONSENT: (complete for all Medication/Procedures at school)

1. This medication order is in effect for this school year.
2. I will supply medication in its original, updated, properly labeled container.
3. I understand that medication cannot be sent to school by a student, and must be dropped off/picked up by an adult.
4. I will obtain a new physician's order and notify the school in writing of any changes.
5. I authorize the school nurse to exchange information verbally or in writing with my child's physician regarding this medication or the conditions for which it is prescribed.
6. I understand that non-medically licensed school personnel will administer medications.
7. My signature indicates that I have fully read and understand the above information.

Signature of Parent/Legal Guardian_____**Date** _____

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PHYSICIAN ORDER: *Prescription Medication or over-the-counter medications that exceed the recommended packaging dose)*

[ ] **I have determined that the medication/procedure named above is necessary during the school day. The above medication is to be administered during the school day in accordance with the above instruction and agreements.**
I agree to accept communication about student/medication and understand that non-medically licensed school personnel will give the medication. Please contact me if the following medication side effects or symptoms occur:

_____

Physician Name:_____Phone:_____Fax:_____

X_____

Signature of Physician/Practitioner Date

Scan and email completed form or fax to 920-492-2999
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For office use only: Scanned_____ Med____ Entered____