ASHWAUBENON
SCHOOL DISTRICT

MEDICATION ADMINISTRATION REQUEST/CONSENT FORM

Ashwaubenon School District Fax numbers
Cormier Early Learning Center 920-448-2873 Pioneer Elementary School 920-492-2987
Valley View Elementary 920-492-2340
Parkview Middle School 920-492-2944 Ashwaubenon High School 920-492-2912

Medications are to be administered 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. One form for EACH medication is required.

Name of Student: _____ School: _____ Grade: _____
Date of Birth: _____ Physician Name:_____ Phone:_____

Medication /Procedure:

Name of Medication or Procedure: _____

Reason for Medication or Procedure: _____

Method: □ oral □ inhaled □ nebulizer □ injectable □ topical □ eye □ ear □ other_____
Dose: _____ □ Daily or □ As needed Time to be given:_____

Dates to be given: From:_____To: _____
If medication is to be given on an as needed basis (PRN), state conditions under which medication should be given:

_____

Additional Directions:

_____

_____

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

- **I request and authorize that school personnel administer this medication/procedure at school.**
- **I will supply medication in its original, updated, properly labeled container. (Request extra bottle for school from pharmacy.)**
- **This order is in effect for this school year.**
- **I will obtain a new physician's order and notify the school in writing of any changes.**
- **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.**
- **I understand that all medication is to be transported to and from school by parent or adult and picked up by parent or adult at the end of the school year or it will be discarded. NO MEDICATION will be sent home with students.**
- **I understand that non-medically licensed school personnel will administer medications.**
- **My signature indicates that I have fully read and understand the above information.**
- **ASTHMA INHALERS AND EPI PENS ONLY:** This student is capable of self-administration and may carry inhaler or EPI pen and self- administer in school. □ Yes □ No

_____ _____ _____
Signature of Parent/Legal Guardian **Telephone Home/Cell** **Date**

PHYSICIAN ORDER*: (required for all Prescription Medication/ Food supplements or natural products /or over-the- counter medications that exceed the recommended packaging dose)*

ASTHMA INHALERS AND EPI PENS: This student and his/her parents/guardians have been instructed in self-administration and this student may carry an inhaler or EPI pen and self-administer in school. □ Yes □ No

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: _____

_____

_____ _____ _____
Signature of Physician/Practitioner Date Printed Name Physician/Practitioner Phone number