PRESCRIPTION MEDICATION PARDEEVILLE SCHOOL DISTRICT CONSENT FORM

Elementary (608) 429-2151 Fax (608) 429-4807
Middle/High School: (608) 429 – 2153 Fax (608) 429-2277

SCHOOL **(circle one)**: Elementary Middle School High School

STUDENT'S NAME_____ DOB_____ Grade_____
Address_____ Phone_____
PHYSICIAN_____ Phone_____
Address_____ Fax_____

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.

One form for **EACH** medication is required.

All medication must be in the original prescription container.

Name of medication_____Date Start_____Date End_____
Dosage_____Frequency_____
Route(circle choice) **ORAL TOPICAL**
Possible Side Effects_____
If medicine is to be given when needed, describe conditions under which to administer _____
_____

Permission is given to the school to administer early A.M. dose of medication if forgotten at home (per parent/guardian request). (Circle choice) **YES NO**

ASTHMA INHALERS AND EPI-PENS ONLY:

This student and his/her parents/guardians have been instructed in self administration and students may carry an inhaler or EPI pen and self-administer in school. (Circle choice) **YES NO**

PARENT/GUARDIAN CONSENT: .

- I request and authorize that this medication be administered at school by school personnel.
- I will supply medication in its original, updated, properly labeled container.
- This order is in effect for this school year unless otherwise indicated.
- I will obtain a new physician's order and notify school in writing for any changes. • I authorize school personnel to exchange information verbally or in writing with school personnel and/or my child's physician regarding this medication or the conditions for which it is prescribed.
- I understand that the medication must be brought to school by an **ADULT**.
- I understand that when medication at school is no longer needed, an **ADULT** will pick up the remaining medication. **It will not be sent home with the child.**
- I understand that medication will be given by non-medically trained school personnel.
- 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 at school.

----------**REQUIRED SIGNATURES**----------

The above medication is to be administered during the school day in accordance with the above instructions and agreements. I agree to accept communication about student/medication and understand the medication will be given by non-medically trained school personnel.

Parent/Guardian Signature gives permission for the school to dispense medication/treatment as described above and allow discussion of medical conditions with Physician/practitioner. Parent/Guardian is responsible for contacting school if the plan is to be changed/withdrawn.

Parent/Guardian Signature_____Date_____

Physician/Practitioner Signature_____Date_____ (Required if medicine is a prescription)

Physician Name (print):_____Phone_____

02/2024