# Parent-Physician Medication Consent Form

6300 Alderson Street
Weston WI 54476

District policy states that ALL prescription medication given at school, including students who carry and self-administer inhalers and Epi-pens, have written instructions signed by the physician and the parent/guardian. No physician signature is required for OTC medication *providing* the dose is within the manufacturer's guidelines.

It is understood that:

1. All medications must be in an ***original over the counter (OTC) and/or pharmacy container*** with student's name, name of medication, dose and time of administration on the label and/or container.
2. ***For students' safety***, medications sent in baggies or not in the original package will not be given by staff.
3. Students will be taken to the emergency room after using an Epi-pen or giving Glucagon.
4. Students are responsible for taking self-carried, emergency medications on field trips.
5. Students must notify a staff member if they use an emergency medication(s) at school.

Name of student: _____ Date of Birth: _____
Address: _____ Phone: _____
School: _____ Grade: _____
Medical diagnosis(es): _____

## MEDICATION INSTRUCTIONS

| Medication | Dosage | Frequency | Times given at home | Times given at school |
|---|---|---|---|---|
| | | | | |
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| | | | | |
| | | | | |

Medication order effective from: _____ until: _____

**Emergency Medication Administration Section: Check all boxes that apply.**
Student understands the correct use of his/her emergency medication.
Student has permission to self-carry and self-administer the medication as needed at school.

- Epi-pen for anaphylactic life threatening reactions ☐**Yes** ☐**No**
- Inhalers for breathing emergencies. ☐**Yes** ☐**No**

## PHYSICIAN–PARENT CONSENT

Physician's signature authorizes staff to give the listed medication to my son/daughter. I hereby give permission to the staff designated by school principal or district nurse to give the above medication to my son/daughter according to the instructions stated above and authorize them to contact the physician if necessary. A new form is needed when there are changes in the dose of medication or if the medication is discontinued. Consent is valid for the current school year.

Physician's name, address, phone

_____
_____
_____
_____

_____
Physician's signature/date

_____
Parent/guardian signature

_____
Date

Exhibit Approved: 8/28/01