Wonewoc-Center School District

Home of the Wolves

101 School Road, Wonewoc, WI 53968

JODI WELDY
SCHOOL NURSE

PHONE: (608) 464-3165 ext. 131
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Medication Request/Consent Form

THIS FORM COVERS ONLY ONE (1) STUDENT AND ONLY (1) MEDICATION

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: _____ Date of Birth: _____ Grade: _____

Address: _____ Phone: _____

Medication/Procedure: _____
Reason for medication (diagnosis): _____
Dose to be given: _____
Time to be given: _____
Dates to be given: From: _____ To: _____

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

- I request and authorize that this medication be administered by school personnel.
- I understand that medication may be given by non-medically trained school personnel.
- I will supply medication in its original, updated, properly labeled container. (Request extra bottle from pharmacist.)
- This order is in effect for this school year unless otherwise indicated.
- I will obtain a new physician's order and notify the school in writing for any changes.
- I authorize school personnel to exchange information verbally or in writing with my child's physician regarding this medication or the conditions for which it is prescribed.
- I further understand that all medication should be delivered to the school by parent/guardian.
- I will pick up unused medications at the end of the school year. Unclaimed medications will be discarded.
- 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.
- 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 Business Date

PHYSICIAN ORDER: (complete for all prescription Medication/Procedures.)

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. Please contact me if the following symptoms occur: _____

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

_____ _____ _____
Physician Printed Name Address Phone

_____ _____
Signature of Physician Date