WONEWOC-CENTER SCHOOLS GENERIC HEALTH PLAN

Student_____ **Date of Birth**_____
Grade_____ **Teacher**_____ **School Year**_____
Parent/Guardian_____ **Phone Number**_____
Practitioner_____ **Phone Number**_____

Medical condition(s): _____
_____

Usual treatment:_____
_____
_____

Medication	Dosage	Time(s)	Taken at home or school

☐My child does not take any medication at home or at school

Side Effects of medications: _____

Signs of emergency: _____

Actions for teacher/nurse to take: _____

PARENT/GUARDIAN CONSENT:

- 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.

_____ _____
Signature of Parent/Legal Guardian Date

PHYSICIAN ORDER:

The above medication(s) 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 may be given by non-medically trained school personnel. Please contact me if the following symptoms occur:

_____

_____ _____ _____
Physician Printed Name Address Phone

_____ _____
Signature of Physician Date