ISD #518 Worthington Consent for Medication Administration

ALL PRESCRIPTION MEDICATION REQUIRES A PHYSICIAN'S SIGNATURE

___Prairie# 507-727-1250 Fax# 507-727-1255 ___WMS# 507-376-4174 Fax# 507-372-1424

WHS# 507-376-6121 Fax# 507-372-4304 ___Intermediate# 507-727-1275 Fax# 507-727-1277

___Learning Center# 507-372-1322 Fax# 507-727-1125

Student: _____ **Date of Birth**: _____ **Grade**: ____

Parent/Guardian: _____Phone: _____(W)_____

1. **Reason** for medication/treatment: _____

2. Name of **Medication** _____**Dosage:** _____
( ) tablet/capsule ( ) liquid ( ) inhaler ( ) nebulizer ( ) other _____

3. **Time** Medication is to be given **AT SCHOOL**: _____ ( ) with lunch ( ) PRN-as needed
Give medication on ( )late start ( )early dismissal days

4. **Start** Date: _____ **End** Date: _____ ( ) end of school year

5. **Restrictions** and/or **side effects**: _____ ( ) non anticipated
6. **For students with more than once daily dosing**: If the morning dose usually taken at home is missed, this dose may be administered at school by school personnel. **PARENT/GUARDIAN** is required to notify school of missed dose at home.

_____

Physician's Signature (for ALL prescription medications) **Date**

_____

Physician name-printed

Insulin, Epi-pens, & inhalers: I have assessed this student and found him/her to be both capable and responsible for **SELF-ADMINISTERING/SELF CARRYING** this medication (school district is not responsible for missed doses of medication):
( ) not applicable ( ) no ( ) yes, with supervision ( ) yes, unsupervised – may carry during school hours
**a photocopy of the prescription is acceptable in place of physician's signature unless the student is going to self-administer/self-carry the medication.

I authorize school personnel to set-up and administer the above medication to my child (unless self administration/self carry has been indicated). I understand that the **medication must be provided in a pharmacy or unopened manufacturer's labeled bottle.** Medication in plastic bags or envelopes **WILL NOT** be accepted.

***This notice gives permission for the school health office and this doctor's office to share information regarding this student's health condition to better care for the child during school hours. I give my permission for my child's medical office to fax this form to my child's school.
___(initial) **I give permission to send remaining medication home with my child at the end of the school year or when treatment is complete. (Controlled substances must be picked up by parent/guardian)**

Parent/Guardian Signature **Date** **8/22wd**