Lafayette County Health Department

729 Clay Street - Darlington, Wisconsin 53530
(608) 776-4895 - Fax (608)776-4885

MEDICATION ADMINISTRATION CONSENT FORM

Student Name:____ Grade/Teacher:___________________

Birth Date:_________________________ Allergies:____

NOTE TO PARENTS/GUARDIANS
The School District **REQUIRES** that students who need prescription medication during school hours **MUST** do the following:

1. Present a written consent form filled out and signed by the parent and **PHYSICIAN**. (Form below. If form is unavailable, a prescription pad form signed by the physician may be used.)
2. Bring the prescription medication in the original prescription container, properly labeled by a pharmacist.

CONSENT FOR MEDICATION PRESCRIBED BY A PHYSICIAN

Medication:_______________________________________ Dosage:_____________________________

Time to be given:____

If needed, how often can administration of medicine be repeated?________________________________

Reason for Medication to be given:____

Precautions: ____

If the medication is an inhaler, please answer the following questions:

Where is the inhaler to be stored?

- ☐ in designated area (health room, nurse's office)
- ☐ in student's possession
- ☐ in designated area & in student's possession (be sure to send 2 inhalers)

( ) I have instructed __________________________ in the proper way to use his/her inhaled asthma medications. It is my professional opinion that he/she should be allowed to carry and use this inhaled medication by him/herself.

( ) It is my professional opinion that ____________________ should not carry and use his/her inhaler asthma medication by him/herself.

Physician Signature/Phone____ Date:________________________

Parent Signature/Phone____ Date_________________________

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Student Name:____ Grade/Teacher:___________________

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NOTE TO PARENTS/GUARDIANS
The School District **REQUIRES** that students who need over-the-counter medication during school hours **MUST** do the following:

1. Present a written consent form filled out and signed by the parent or legal guardian. (Consent form below)
2. Bring over-the-counter medication in the original container. Do not send medication in plastic baggies, envelopes, or other unmarked containers.

NOTE: Many of the short-term medications do not need to be given at school. For example medication taken 3 times per day can be given in the morning before school, right after school, and at bedtime.

CONSENT FOR MEDICATION OVER-THE-COUNTER MEDICATION

Medication:_____________________________________ Dosage:________________________________

Time to be given:____

Reason for Medication to be given:____

By signing below, I give school personnel permission to administer the above indicated non-prescription medication to my son/daughter. I understand that all medication should be in their original container. I give permission that necessary information related to my child's condition be shared with the school nurse

____

Parent Signature Date