

# School District of Benton

## Benton School Board

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41 Alma Street, PO Box 7  
Benton, WI 53803  
Phone (608)759-4002  
Fax (608)759-3805  
[www.benton.k12.wi.us](http://www.benton.k12.wi.us)

## MEDICATION ADMINISTRATION CONSENT FORM: Prescriptions

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 \_\_\_\_\_