School District of Black River Falls

PRESCRIPTION MEDICATION FORM FOR SCHOOL ADMINISTRATION: _____

School year/effective dates

STUDENT INFORMATION (TO BE FILLED OUT BY PARENT/GUARDIAN)

PHOTO ID (OPTIONAL)

_____ _____ _____

Student's Name Birthdate Grade

_____ _____ _____

Medication Dosage Time/Frequency

_____ _____

Reason for Medication Physician's name

Medication Allergies:_____

NOTE: For prescription medications: Signed Parent Consent **and** signed Physician's Order **required**.

PARENT CONSENT: Complete for EACH PRESCRIPTION MEDICATION AT SCHOOL (Please review your school's handbook for specific information regarding the medication policy)

- I request that this medication be administered at school.
- Medication will be supplied in its original, properly labeled container.
- This order is in effect for this school year unless otherwise indicated.
- I will notify the school in writing for any changes and obtain a new physicians order
- I authorize school personnel to exchange information verbally or in writing with my child's physician regarding this medication or the condition for which it is prescribed.
- I release the school district from any liability claim as a result of the administration of this medication or procedure as directed.

_____ _____ _____ _____

Date Parent's Signature Address and City Telephone #

****All medication MUST be brought in by PARENT or other responsible ADULT. Under NO circumstance, shall medication be sent to school with the student. This is in accordance to Wisconsin State Law.**

PHYSICIAN ORDER: Complete for EACH PRESCRIPTION MEDICATION AT SCHOOL

The above medication is to be administered during the school day in accordance with the above instructions.

Please contact me if the following symptoms occur: _____

Additional Information: _____

For Asthma inhalers and Epi-pens ONLY: Student may carry inhaler/pen in school Yes No

_____ _____ _____

Date Physician Signature Telephone #