WRIGHTSTOWN COMMUNITY SCHOOL DISTRICT

Medication Request/Consent Form (One Medication Request per Form) Revised (2/2014)

GRADES PreK - 8

Medications are to be administered at home whenever possible. If it is necessary for a student to receive medications at school, all appropriate portions of this form must be completed before medication can be given at school. One form for EACH medication is required.

Name of Student: ___________________________ Birthdate: ___________School:_________ Grade: _______Teacher______

Parent's Name _______________________ Phone: ____________________ Alternate Phone: _________________________

Physician Name: ________________________ Phone:_____________________

Medication:
Name of Medication: ____

Reason for medication____

Method: _oral _inhaled _nebulizer _injectable __other____

Time to be given: _______________________________ Dose:________________________

_Daily or _As needed Dates to be given - From: _______ to: _______ End of school Year

If medication is to be given on an as needed basis (PRN), state conditions under which medication is to be given: ______________

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How soon can administration of medication be repeated? ____

Additional Directions:____

Precautions/Unfavorable Reactions:____

PARENT/GUARDIAN CONSENT: (complete for all Medications at school)

- I request and authorize that school personnel administer this medication at school.
- I will supply medication in its original, updated, properly labeled container. (Request extra bottle for school from pharmacy.)
- I will obtain a new physician's order and notify the school in writing for any changes.
- I authorize the school nurse 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 is to be transported to and from school by parent/guardian.
- I understand that non-medically licensed school personnel will give medication.
- I hereby release the Wrightstown Community School District Board of Education and its agents and employees from any and all liability that may result from my child taking the medication identified on this form.

_ **ASTHMA INHALERS ONLY**: This student is capable of self-administration and may carry inhaler and self-administer in school.
__Yes __No

________________________________ ________________/________________ ___________________________

Signature of Parent/Legal Guardian **Telephone Home** **Business** **Date**

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PHYSICIAN ORDER: (required for all Prescription Medication or over-the-counter medications that exceed the recommended packaging dose)

ASTHMA INHALERS ONLY: This student and his/her parents/guardians have been instructed in self-administration. It is my professional opinion that this student may carry an inhaler and self-administer in school.
__Yes __No

The above medication is to be administered during the school day in accordance with the above instruction and agreements. I agree to accept communication about student/medication and understand that non-medically trained school personnel will give the medication. Please contact me if the following symptoms occur: ___________________________________

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___________________________ __________________ _____________________________________

Signature of Physician/Practitioner **Date** **Printed Name and Address of Physician/Practitioner /Phone Number**