**Wrightstown Community School District**
**Medication Request/Consent Form (One medication Request per Form) Revised (1/2017)**
# Grades 4K-12

## Student Information

Name of Student: _____ Birthdate: _____

School: _____ Grade: _____ Teacher: _____

Physician Name: _____ Phone: _____

## Medication:

Name of Medication: _____

Medication Expiration Date_____ Time medication to be given_____Route of medication_____

Reason for Medication: _____

Dose: _____Daily_____ or As Needed_____ Dates to be given: From_____ to_____End of school_____

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

_____

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 or health aide to exchange information verbally or in writing with my child's physician regarding this medication or 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.

**Self-Administration/Self-Carry of Asthma Inhaler, Epinephrine Auto Injectors, Insulin, Glucagon, Diastat: This student and his/her parents/guardians have been instructed in self-administration. ___YES __ NO**

_____ _____ _____
Signature of Parent/legal Guardian Date Telephone Number

## PHYSICIAN ORDER: Required for all prescription Medication or over-the- counter medications that exceed the recommended packaging dose

**Self-Administration/Self-Carry of Asthma Inhaler, Epinephrine Auto Injectors, Insulin, Glucagon, Diastat: This student and his/her parents/guardians have been instructed in self-administration. ___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 may give the medication. Please contact me if the following symptoms occur:

_____

_____ _____ _____
Signature of Physician/Practitioner Date Printed Name and Address of Physicians/Practitioner/Phone

## High School Only (9-12 Grade)

Student may carry Tylenol/Acetaminophen or Ibuprofen/Advil/Motrin **ONLY** and self-administer according to directions on medication bottle. **Please sign below and fill out Student Information and Parent/Guardian consent sections and return to the Health Office.**

_____ _____
Parent Signature Date