WRIGHTSTOWN COMMUNITY SCHOOL DISTRICT

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

GRADES 9 - 12

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 __Self-Administration (High School) 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: _____

_____

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.

Self-Administration of Medication/Asthma Inhaler (EXCLUDES controlled substances): I hereby give permission and feel this student is capable of self-administration and may carry and self-administer the above medication in school. I believe this student is sufficiently responsible to keep this medication in his/her possession and control its use. __Yes __No

_____ _____/_____ _____

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

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

Self-Administration of Prescription Medication/Asthma Inhalers (EXCLUDES controlled substances): This student and his/her parents/guardians have been instructed in self-administration. It is my professional opinion that this student may carry and self-administer the above medication in school. I believe this student is sufficiently responsible to keep this medication in his/her possession and control its use. __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: _____

_____

_____ _____ _____

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