

Nekoosa School District
_____ School Year

Parent/Guardian Consent Form for Medication
Clinician's Order for Administration of Prescription Medication

(Please Type or Print)

This order and consent for medication is required to be completed and presented to the child's school before any medication may be administered to a child during the school day.

Name of Student _____ DOB _____ Grade _____
Address _____
Home Phone Number _____ Mother Cell # _____ Father Cell # _____

ALL MEDICATION MUST BE IN ITS ORIGINAL CONTAINER

- I grant permission to the persons designated by the principal to give medication(s) to my child according to the directions.
- I authorize school personnel to exchange information with my child's clinician regarding this medication or the condition for which it is prescribed.
- I release the school district from any liability claims of the administration of this medication as directed.
- I will notify the school in writing of any changes. Prescription medication changes require a new clinician order.
- My child may take medication(s) at school without authorized school personnel dispensing the medication(s) Yes ___ No ___
- I understand all medication must be picked up at the end of the school year or it will be destroyed. I give my student permission to transport medication to and from school, and will not hold the school liable for any accident, injury, or loss of medication that may occur during transport. Yes ___ No ___

Name of non-prescription medication (Example Tylenol): _____
Scheduled time for dose _____ As needed at student's request _____
Dosage _____ Frequency _____ Entire school year Yes ___ No ___ or
number of days _____ (maximum 5 consecutive days without medical prescription)

Authorized school personnel may give my child medication as listed by parent or clinician.

Signature of Parent/Guardian _____ Date _____

Clinician's Order for Each Prescription Medication (Additional space on back)

Clinician's Name _____

Clinic _____ Clinician's Phone Number _____

Diagnosis _____

Medication Allergies _____

Medication _____

Dose _____ Frequency _____

Route: Oral ___ Other ___ Duration: Entire school year ___ Number of days _____

Condition under which medication should be given (PRN medications) _____

The student may take medication at school without authorized school personnel dispensing the medications. Yes ___ No ___
(Example asthma inhalers or insulin)

Clinician's Signature _____ Date _____

Clinician signature required for all prescription medications

#2 Prescription Medication _____

Dose _____ Frequency _____

Route: Oral _____ Other _____ Duration: Entire school year _____ Number of days _____

Condition under which medication should be given (PRN medications) _____

The student may take medication at school without authorized school personnel dispensing the medications. Yes _____ No _____

(Example asthma inhalers)

Clinician's Signature _____ **Date** _____

Clinician signature required for all prescription medications

#3 Prescription Medication _____

Dose _____ Frequency _____

Route: Oral _____ Other _____ Duration: Entire school year _____ Number of days _____

Condition under which medication should be given (PRN medications) _____

The student may take medication at school without authorized school personnel dispensing the medications. Yes _____ No _____

(Example asthma inhalers)

Clinician's Signature _____ **Date** _____

Clinician signature required for all prescription medications

#4 Prescription Medication _____

Dose _____ Frequency _____

Route: Oral _____ Other _____ Duration: Entire school year _____ Number of days _____

Condition under which medication should be given (PRN medications) _____

The student may take medication at school without authorized school personnel dispensing the medications. Yes _____ No _____

(Example asthma inhalers)

Clinician's Signature _____ **Date** _____

Clinician signature required for all prescription medications