PULASKI COMMUNITY SCHOOL DISTRICT, PULASKI, WISCONSIN
Medication Request/Consent Form

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

Student Name: _____ School: _____ Date: _____

Address: _____ Phone: _____ Birthdate: _____

Physician: _____ Address: _____ Phone: _____

MEDICATION:

Name of Medication: _____

Reason for Medication: _____

Method: **[ ]** oral **[ ]** inhaled **[ ]** injectable **[ ]** topical **[ ]** eye **[ ]** ear **[ ]** other _____

Time to be given: _____ Dose: _____

[ ] Daily **[ ]** As needed Dates to be given - **[ ]** School Year **OR** From: _____ to _____

How soon can administration of medication be repeated? _____

Additional Directions: _____

Precautions/Unfavorable Reactions: _____

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

- I request and authorize school personnel to administer this medication at school
- I will supply medication in its original, updated, properly labeled container (request extra bottle from pharmacy)
- This order is in effect for the school year unless otherwise indicated
- I will obtain a new physician's order and notify the school in writing of 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 agree to hold the School District, its employees, and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication at school
- My signature indicates that I have fully read and understand the above information
- **ASTHMA INHALERS:** This student is capable of self-administration and may self-carry an inhaler **[ ]** Yes **[ ]** No
- **EPINEPHRINE AUTO-INJECTOR:** This student is capable of self-administration and may self-carry an epinephrine-autoinjector **[ ]** Yes **[ ]** No

_____ _____ _____
Signature parent/legal guardian Telephone home/business Date

PHYSICIAN ORDER: (required for all prescription medication/food supplements or natural products / or over-the-counter medications that exceed the recommended packaging dose)

ASTHMA INHALERS: This student is capable of self-administration and may self-carry an inhaler **[ ]** Yes **[ ]** No
EPINEPHRINE AUTOINJECTORS: This student is capable of self-administration and may self-carry an epinephrine-autoinjector **[ ]** Yes **[ ]** No

The above medication is to be administered during the school day OR at a school-sponsored activity with the above instruction and agreements. I agree to accept communication about the student/medication and understand that non-medically licensed school personnel will give the medication. Please contact me if the following symptoms occur _____

_____

_____ _____ _____
Signature of licensed medical provider Printed name and address/telephone number Date