**DODGELAND SCHOOL DISTRICT**
**PRESCRIPTION MEDICATION CONSENT FORM**
**Fax # 920-386-4498**

This order for prescription medication is required to be completed and presented to the school a student attends before any prescription medication may be administered to a student in accordance with section 118.29 (2)(a)(2) of state statutes, Board policy and District procedures.

Student Name _____ Grade _____

Home Address _____

Parent/Guardian Name _____

Phone Numbers (home)_____ (work) _____ (cell) _____

Prescribing Health Care Practitioner _____ Phone _____

Reason for Medication(s) _____

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**COMPLETED BY PRESCRIBING HEALTH CARE PRACTITIONER**

Daily Medication and P.R.N. Medications (as is needed)

| Medication | Dose | Route | Time(s) To Be Given | Duration (From-To) | For P.R.N. Medication - Condition Under Which Medication Should Be Given | Conditions or Adverse Reactions Requiring Parental and/or Practitioner Notification *(If none, state this)* |
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- I agree to retain the power to direct, supervise, decide, inspect and oversee the administration of such medication(s).
- With applicable parent/guardian (or adult student) consent, direct contact may be made to address questions or concerns.
- ☐ *(check only if applicable)* I give approval for the student to self-administer the following medication(s)

_____

Hospital/Clinic/Office Name _____Phone _____

Address: _____

Signature of Prescribing Practitioner _____ Date _____

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**COMPLETED BY PRINCIPAL AND/OR SCHOOL NURSE**

☐ *(check only if applicable)* The student has approval to self-administer the following medication(s)

_____

**PLEASE COMPLETE BACK SIDE**

**COMPLETED BY PARENT/GUARDIAN (OR ADULT STUDENT)**

I agree to the following:

- I understand that the District Administrator and/or Principal may authorize an employee to administer prescription medication to students and I give permission to the designated trained employee to administer the medication(s) to my child according to the directions stated above.
- ☐ *(check only if applicable)* I give approval for my child to self-administer the following medication(s)

  _____

- I give consent for the exchange of necessary information between the prescribing practitioner and school personnel.
- I will hold the Dodgeland School District, its employees and agents who act within the consent granted by this document, harmless in any and all claims arising from the administration of medication (as identified above) at school or school-related activities.

Signature of Parent/Guardian _____ Date _____

Signature of Student (age 18 or older) _____ Date _____