DODGELAND SCHOOL DISTRICT
PRESCRIPTION MEDICATION CONSENT FORM

This order for 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.

Name of Student: _____ School: _____ Grade: _____

Home Address: _____

Name of Parent/Guardian: _____

Phone Numbers: (home) _____ (work) _____ (mobile) _____

Name of Prescribing Health Care Practitioner: _____ Phone: _____

Reason for Medication(s): _____

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)*

- 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: _____

Completed by Principal and/or School Nurse

- Name of Person(s) Designated to Administer the Prescription Medications (listed above):
  1. _____ 2. _____
- ☐ *(check only if applicable)* The student has approval to self-administer the following medication(s): _____

_____

Completed by Parent/Guardian (or Adult Student)

I agree to the following:

- Give permission to the designated school personnel 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): _____

_____

- Give consent for the exchange of necessary information between the prescribing practitioner and school personnel.
- 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: _____

(Revised: December 2014)