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 LISTING INGREDIENTS AND DOSAGE RECOMMENDATIONS

- 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_____
- Non-prescription dosing may not exceed package recommended dosing without a clinician written order.

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

Wisconsin Statute 118.29, 118.291

#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

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#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

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#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