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 medications at school, all appropriate portions of this form must be completed before medication can be given at school. One form for EACH medication is required.

Name of Student:______________________________School:_____________Grade: __________

Address:___________________________________Phone:_____________Birthdate: _________

Physician Name:__________________________Address:________________Phone:__________

Medication /Procedure:

Name of Medication or Procedure: ____

Reason for medication/procedure: ____

Method: [ ] oral [ ] inhaled [ ] nebulizer [ ] injectable [ ] topical [ ] eye [ ] ear [ ] other__________

Time to be given:_____________________ Dose:________________

[ ] Daily or [ ] As needed Dates to be given – [ ] school year **OR** From:_________to:__________

If medication is to be given on an as needed basis (PRN), state conditions under which medication is to be given:
____

How soon can administration of medication be repeated? ___________________________________

Additional Directions:____

Precautions/Unfavorable Reactions:____

PARENT/GUARDIAN CONSENT: (complete for all Medication/Procedures at school)

- I request and authorize that school personnel administer this medication/procedure at school.
- I will supply medication in its original, updated, properly labeled container. (Request extra bottle for school from pharmacy.)
- This order is in effect for this 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 carry inhaler [ ] Yes [ ] No
- ***EPI PENS ONLY:*** This student may self-carry epipen [ ] Yes [ ] No

_________________________ ____________/____________ ________________
Signature of 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 carry inhaler [ ] Yes [ ] No
EPIPENS ONLY: Student may self-carry epipen [ ] Yes [ ] No

The above medication is to be administered during the school day in accordance with the above instruction and agreements. I agree to accept communication about student/medication and understand that non-medically licensed school personnel will give the medication. Please contact me if the following symptoms occur: __________
____

_____________________ ____________ ____
Signature of Physician/Practitioner Date Printed Name and Address of Physician/Practitioner/Phone Number