School District of Iola-Scandinavia-Confidential Health Services
Administration of Medication Consent (Wisconsin Statute 118.29)

Top part to be completed by Parent/Guardian

Students Name:	Date of Birth:
Grade:	School Year:
Bus student: (Circle one) YES NO	

A separate form is needed for <u>each</u> medication!!

Medication: _____

( ) **Prescription**-medication must be provided to school personnel in a pharmacy labeled container along with the prescribing physician's signature (See box below)

( ) **Non-prescription**-medication must be provided to school personnel in the ORIGINAL container.

Dosage: _____ Frequency/Time: _____

Reason for medication: _____

If medication is to be given "as needed," list conditions under which medication should be given _____

_____

Any precautions, side effects or adverse reactions from taking this medication _____

_____

I hereby give my permission for designated school personnel to give this medication to my child according to the directions stated above and to contact my child's physician if necessary. I agree to notify the school in writing when any change in the above orders is necessary. I further agree to hold the School District of Iola-Scandinavia and designated school personnel harmless in any and all claims arising from the administration of this medications, according to policy at school.

Signature of Parent/Guardian: _____Date: _____

Telephone #: Home _____ Work _____Cell _____

To be completed by Prescribing Physician:

For Prescription Medication:

___Administer to student as directed above on pharmacy labeled container

For inhaled Medication:

___I have instructed the student in the proper way to use his/her inhaler. It is my professional opinion that this student should be allowed to carry and use the medication by him/herself.

___It is my professional opinion that the student should NOT carry inhaled medication by him/herself.

For Epi-Pen:

Is the student knowledgeable about his/her medication? ( ) Yes ( ) No

Has the student demonstrated the proper technique in administering medication? ( ) Yes ( )No

___It is my professional opinion that he/she should be allowed to carry and self-administer Epi-Pen.

___It is my professional opinion that he/she should NOT be allowed to carry and self-administer Epi-Pen.

Physician Signature: _____ Date: _____

Physician Name (please print): _____

Address: _____

Office Telephone #: _____ Fax #: _____