MUSKEGO NORWAY SCHOOLS

MUSKEGO-NORWAY SCHOOL DISTRICT **453.4(E-1)**
PARENT/PHYSICIAN CONSENT FORM

PRESCRIPTION MEDICATION

ALL PRESCRIPTIONS EXCEPT "EMERGENCY" MEDICATIONS (including but not limited to epinephrine, glucagon, inhalers, and diabetic management medications) MUST BE STORED AND ADMINISTERED IN THE HEALTH OFFICE.

I hereby request and authorize that

_____ _____ of _____
(Student's Name) (Grade) (School)

_____ receive medication from a trained staff member or designated volunteer appointed by the school principal

_____ carry and self-administer (student who is grade 7 or above or individuals approved by the school nurse) medication under the guidance/direction of myself

I shall supply a properly labeled container of medication in its original packaging. The label shall include the name and telephone number of the pharmacy, the student's name, the name and telephone number of the prescribing physician, the name of the medication, effective dates, directions for administering, the medication's storage requirements, dosage and time to be given. I understand that the school is not responsible for the loss of medication due to carelessness on the part of the student. I also understand that I am responsible for supplying medication.

I hereby give permission to my child to take the medication according to the directions stated above and further authorize them to contact the child's physician if warranted. I agree to hold the Muskego-Norway School District harmless in any and all claims arising from the benefits or consequences of this medication which the physician has prescribed and my child has taken. Furthermore, I agree to hold the district harmless of any responsibility for assuring that the medication is taken. In the event a student refuses to take a medication that a parent/guardian has consented to, District staff will contact the parent as soon as practicable to make them aware of the missed dose.

I understand that, if my child self-administers the medication, he/she is not authorized to make this medication available to other students and if he/she does dispense the medication to others, this is cause for immediate revocation of the self-administration privilege and will be cause for appropriate disciplinary action against him/her.

I hereby give permission to trained personnel or designated volunteer to give the medication to my child according to the directions stated above and further authorize them to contact the child's physician if warranted.
I, the undersigned, hereby authorize the Muskego-Norway School District staff to disclose by any means (including written, oral, or electronic) information regarding this form to the physician listed.
I, the undersigned, hereby authorize the physician listed on this form to disclose by any means (including written, oral, or electronic) information regarding this form to the Muskego-Norway School District.

_____ _____
(Signature of Parent/Legal Guardian) (Date)

PHYSICIAN'S ORDER FOR PRESCRIPTION MEDICATION

Your signature on this document attests to your willingness and intent to direct, supervise, decide, and oversee the administration of the medication by the student or the trained staff member/designated volunteer. Your signature attests that you are willing to accept direct communication from the person dispensing or administering the medication.

_____ is qualified and/or able to self administer this medication.
(Student's Name)

ALL INSTRUCTION MUST BE STATED IN THE LANGUAGE OF THE LAY PERSON ADMINISTERING THE MEDICATION.

Name of Student_____ **Date of Birth**_____

DRUG: NAME_____ **DOSE/STRENGTH**_____ **PURPOSE**_____

ROUTE_____ **FREQUENCY**_____ **TIME(s) OF DAY**_____

IF "TO BE GIVEN AS NEEDED," for what symptoms? _____

Date Effective:_____ **to** _____ ***Note: This consent form must be renewed annually***

Physician's Name (printed)_____ **Phone**_____

Physician's Signature_____ **Date**_____

Please return this form to the health room/office. Without the form we cannot dispense the medication.