MUSKEGO NORWAY SCHOOLS

Our Mission: Every student learning, growing... succeeding.

Prescription Medication Order

Student Last Name: ____________________________________ Student First Name: ________________________________

Student Date of Birth: ________________ School: _______________ Grade: ________ Primary Teacher: _________________

I hereby request and authorize that the above named student have the medication identified on this form administered while at school in the following manner (CHOOSE ONE):

______ Administer by trained staff (medication stored and secured by staff)

______ Self-administer (medication stored and secured by staff) [Self-administration is with the approval of the District Nurse]

______ Self-administer (medication carried by student) [Self-administration is with the approval of the District Nurse]

MEDICATION INFORMATION

Medication Name	
Medication Strength or Concentration (Ex. “2mg/1ml”) (Ex. “500mg/tablet”)	
Medication Quantity (Ex. “Two tablets”)	
Administration Frequency (Ex. “Every four hours”) (Ex. “As Needed”) (Ex. “Once at Noon”) (Please do not state “As Needed” without accompanying Reason for Medication)	
Reason for Medication (symptoms, conditions, etc.)	
Route of Medication (oral, topical, etc.)	
Effective Dates of Administration	

ACKNOWLEDGMENTS AND REQUIREMENTS

- SELF-ADMINISTRATION: I understand that if the student self-administers the medication he/she is not authorized to make the medication available to other students and if he/she does dispense the medication to others, this is cause for immediate revocation of self-administration privilege and will be cause for appropriate disciplinary action.
- TRANSPORT OF MEDICATION TO/FROM SCHOOL: Medication must be conveyed to school directly by the parent/guardian or transported by transportation personnel (bus driver and/or bus aide) at parent/guardian request.
- MEDICATION SUPPLY: **I shall supply a properly labeled container of medication**. The label shall include: 1) the student’s name, 2) the medication information as indicated above, 3) the name & phone number of the pharmacy, 4) the name & phone number of the prescribing physician, 5) any storage requirements. Unused medication will be available for pick-up or sent home with the student, at the discretion of the District Nurse, at the end of the school year. Medication remaining in the MNSD health offices after the end of the school year will be properly disposed.
- AUTHORIZATION TO DISCLOSE: I authorize disclosure amongst the MNSD, the prescribing pharmacy, and the prescribing physician in fulfillment of this Order.
- PERMISSION and HOLD-HARMLESS: I give permission for the Muskego-Norway School District (MNSD) to administer the medication as indicated above to the student (or for student to self-administer if indicated). I agree to hold the MNSD harmless in any and all claims arising from the benefits or consequences of this medication, which the physician has prescribed and the student has taken. I agree to hold the MNSD harmless of any responsibility for assuring that the medication is taken. In the event the medication is not administered the parent/guardian shall be contacted as soon as practicable. I understand that the MNSD is not responsible for the loss of medication due to carelessness on the part of the student.
- CHANGE NOTIFICATION: I shall notify the school in writing when a change occurs or at the termination of this Order.
- Please refer to relevant MNSD Policies and Administrative Guidelines for further information at https://www.boarddocs.com/wi/mnsd/Board.nsf/Public

Parent / Guardian Printed Name	**Parent / Guardian Signature**	**Date**
Physician Printed Name	**Physician Signature**	**Date**
Physician Contact Information		

Consent is valid for duration of school year unless otherwise indicated
Please return this form to the health office. Without the form we cannot dispense the medication

Rev 1/2018