PERMISSION FORM FOR MEDICATION ADMINISTRATION TO STUDENT

HUSTISFORD SCHOOL DISTRICT 845 S. Lake Street Hustisford, WI 53034
HS Phone (920) 349-3261 Elem Phone (920) 349-3228
HS Fax (920) 349-8495 Elem Fax (920) 349-3530

Student:_____ Date of birth: _____

School:_____John Hustis ___Jr/Sr High School Date form received by the school: _____

TO BE COMPLETED BY • PHYSICIAN OR AUTHORIZED PRESCRIBER (for prescription drugs) ***AND/OR***
• PARENT/GUARDIAN (for non-prescription/over-the-counter drugs)

Reason for medication: _____

Name of medication: _____ Dosage:_____ Frequency: _____

Type of medication:
___Oral: tablet/capsule/liquid; _Inhaler;_____Nebulizer;_____Injection; _Topical;_____Other _____

Start date: ___Date form received Other date: _____

Stop date: ___End of school year Other date: _____

Restrictions and/or important side effects:
___None anticipated ___Yes; please describe: _____

SPECIAL AUTHORIZATION: ONLY FOR INHALERS AND EPI-PENS
This student is both capable and responsible for self-administering this medication:

___No ___Yes (Supervised) ___Yes (Unsupervised)

This student may carry this medication: ___No ___Yes

Indicate if you have provided additional information:_____On the back side of this form;_____As an attachment

Physician's Name: _ _ Phone: _____

Physician's Signature: _ Date: _____ Fax: _____

*** MUST BE COMPLETED BY PARENT/GUARDIAN (for ALL medications – prescription *and* non-prescription)**

As the parent or guardian of the above mentioned student, I will keep the school district aware of any changes in medication(s) profile or health concern of my child. I give permission for my child to receive the above medication at school and school sponsored functions and will not hold the Board of Education or its personnel responsible for complications related to the medication.

As a part of the Wisconsin Statute Chapter 118.29, Administration of Drug to Pupils and Emergency Care, school districts are required to have permission from a medical provider and parent to administrator medications at school. I authorize school district employees to contact the medical provider with questions regarding the medication administration including clarification regarding dosage, side effects or indication of the medication(s) listed above.

Signature:_____ Date:_____ Relationship to Student: _____