Fall River School District

Medication Administration Consent Form

Student Name: ____

Date of Birth: ____________ **Allergies:** ______________________

All medication MUST be in its original over-the-counter or prescription container with a valid expiration date

- Prescription medications: Form must be signed by both parent/guardian & provider.
- Non-prescription medications: Form to be signed by parents/guardian only

Medication name:________________________________

Strength/Dose: ____________ **Amount to be given:**____________________

Reason for Taking Medication:________________**Possible Side Effects:**_____________

Route: ☐ Oral ☐ Nasal ☐ Rectal ☐ Other: _______

Time/Frequency: ☐ Scheduled at:______ ☐ Upon Request Frequency:__________________

Prescribing Provider: _______________________ **Provider Phone #:** _____________

- I understand that medications are to administered at home whenever possible
- I understand that a parent/guardian will be responsible for delivering and picking up medication
- This order is in effect for the school year (including summer school, field trips and after hours school events)
- I will obtain a new physicians order and notify the school in writing of any changes
- I understand that a parent/guardian/responsible adult will deliver all medication to the school
- I am aware that non-medically trained personnel may administer this medication
- I authorize school personnel to exchange information verbally or in writing with school personnel and /or my child's practitioner regarding this medication or the conditions for which it is prescribed.
- I agree to hold the School District, its employees & agents who are acting within the scope of the duties harmless in any & all claims arising from the administration of this medication.

Parent/Guardian Signature:___________________________________**Date:**___________________

PRACTITIONER'S INFORMATION/ORDER:

- The above medication is to be administered in accordance with the written instructions/agreements
- I agree to accept communication about the student/medication
- I understand non-medically trained school personnel may give medication

ASTHMA INHALERS AND EPI-PENS ONLY: This student and his/her parents/guardians have been instructed in self-administration and the student may carry inhaler or epi-pen and self administers in school. YES_____ NO _____

Provider Signature:___________________________ **Date:**__________________

Helping all students achieve to their fullest potential

150 Bradley Street ◆ Fall River, WI 53932 ◆ Phone (920) 484-3333 ◆ Fax (920) 484-3600