CAMPBELLSPORT SCHOOL DISTRICT
Medication Administration By School Staff

This order for medication is required to be completed and presented to the school a child attends before any prescription drug may be administered to the child. (Wisconsin Statute 118.29 (2) (a) (2) .)

Name of Student _____ Address_____ Phone _____

School _____ Grade _____

Physician's Name _____ Physician's Address _____

Diagnosis _____

Medications: Daily or as needed (PRN). **NO MEDICATIONS WILL BE GIVEN UNLESS IT IS IN THE ORIGINAL CONTAINER**

Medication	Dose	Given	Duration	Indicate condition under which med. Should be given. (PRN med. only)	Physicians: Please list condition or adverse reactions which indicate parental and/or physician notification.

I hereby give my permission to the persons designated below to give the medication(s) listed above to my child according to the directions stated above and further authorize them to contact my child's physician. I agree to hold the Campbellsport School District, its employees and agents, who are acting within the scope of their duties, harmless in any and all claims arising from the administration of this medication at school. (Wisconsin Statutes 18.29 (2) (a) (1) (2) (3) (2) (b).)

I agree to notify the school in writing when any change in the above order is made.
Signature of Parent/Guardian _____ Date _____
School staff will not be required to administer any medication by means other than ingestion.

Physician's Signature _____ Date _____
(Physician's signature not required for over the counter medications)
Name of designated person(s) administering medication (to be completed by school principal).
1._____ 2._____ 3._____

_____
Building Administrator