VIROQUA SCHOOL DISTRICT
PRESCRIPTION AND OVER-THE-COUNTER MEDICATION FORM

Medications are to be given at home whenever possible to avoid them being administered during school hours. If it is necessary for a student to receive medications at school, all appropriate portions of this form need to be completed before medication can be given at school and medication must come in the original container.

One form is required for EACH medication.

Student Name:	**Date of Birth:**	**School:**	**Grade:**
Medication Name:	**Dosage:**	**Time/Frequency**	
School Year or Effective Dates:	**Student's Practitioner/Clinic:**		
Reason/Diagnosis for Medication:			

Note: **For prescription medication**: Signed Parent Consent and signed Practitioner's Order required.
For non-prescription medication: Signed Parent Consent required.

PARENT/GUARDIAN CONSENT: (Complete for all Medication/Procedures at school)

- I request and authorize that this medication be administered at school by school personnel.
- **I will supply medication in its original, updated, properly labeled container**. (Request extra bottle from pharmacist.)
- **I further understand that all medication should be delivered to the school by parent/guardian/responsible adult.**
- This order is in effect for this school year only.
- I will obtain a new physician's order and notify the school in writing for any changes.
- I authorize school personnel to exchange information verbally or in writing with my child's practitioner regarding this medication.
- I understand that medication may be given by non-medically trained school personnel.
- **My signature indicates that I have fully read and understand the above information.**

I release the school district from any liability claims as a result of the administration of this medication or procedure as directed.

_____ _____ _____

Date **Parent/Guardian Signature** **Phone #**

PRACTITIONER'S ORDER: The above medication/procedure is to be administered/performed during the school day in accordance with the above instructions and agreements. I agree to accept communication about student/medication/procedure and understand medication may be given by non-medically trained school personnel.

Student and parent/guardian have been instructed and at school, student ***may carry & self-administer:*

Asthma Inhaler Yes_____ No_____ Epinephrine Auto Injector Yes_____ No_____

Practitioner's Name_____ Phone #_____ Fax#_____

Practitioner's Signature_____ Date_____

Clinic_____ Clinic Location_____