WOODS ELEMENTARY SCHOOL
N2575 SNAKE ROAD
LAKE GENEVA, WI 53147
(262)248-3816
FAX(262)248-7021

PRESCRIPTION

PRESCRIPTION MEDICATION ADMINISTRATION CONSENT FORM

(Please print clearly)

Student Name: _____ DOB: _____

PRACTITIONER SECTION

Practitioner Name: _____ Phone #: _____

Diagnosis: _____

Name of medication & strength (e.g. mg.): _____

Time to be administered: _____

Dose & route of administration: _____

Reason for medication: _____

Duration: From _____ to _____

For an as-needed (PRN) medication, state specific conditions under which medication is to be given:

State the side effects for which we should contact you:

Note: Your signature on this document attests to your willingness and intent to direct, supervise, decide, inspect and oversee the administration fo the medication by non-medically trained designee(s) and that you will accept direct communications from them regarding the administration of the medication. We urge that all instructions be stated in language of the lay person. Any changes to this order must be in written form.

_____ _____

Practitioner's Signature **Date**

PARENT/LEGAL GUARDIAN SECTION

I hearby give my permission to Woods School to administer medication to my child according to the directions stated above and further authorize them to contact the child's practitioner if warranted (should the need arise
for the safety of my child and other students). I agree to hold Woods School, its employees and agents who are acting in good faith and within the scope of their duties harmless from any and all claims arising from the administration of this medication at school. I will notify the school in writing whenever this consent is withdrawn prior to the end of the duration period stated above.

_____ _____

Signature of Parent/Legal Guardian **Date**

Note: Person(s) who will be administering medication during school hours are listed in the principal's office. Before a medication will be administered by the school or agent thereof, this form shall be completed and returned to the school principal who shall file and retain the same. A copy must also be kept in the nurse's office. Medications must be in their original containers with the following information printed on the container. 1) Student's full name; 2) Name and dosage of the medication; 3) Time to be given; 4) Practitioner's name. PLEASE ASK FOR AN EXTRA LABEL FROM THE PHARMACY.