MEDICATION ADMINISTRATION

School District of McFarland Health Services

5101 Farwell Street • McFarland, WI • 53558

FAX ➡	MHS: 838-4562	IMMS: 838-4588	WIS: 838-4613	MPS: 838-4612	CE: 838-4503
PHONE 838-4500 ➡	MHS: ext. 4761	IMMS: ext. 4849	WIS: ext. 5454	MPS: ext. 4902	CE: ext. 5613

STUDENT INFO

Student Name _____ Grade _____ School _____

Diagnosis _____ Dose _____ Route _____

Medication name _____ Strength _____ Expiration Date _____

Time of dose to be given _____ Start Date _____ End Date _____

PROVIDER SIGNATURE REQUIRED FOR PRESCRIPTION MEDS/INHALER

PRESCRIPTION MEDICATION AND INHALERS:

Your signature on this document attests to your willingness and intent to direct, supervise, decide, inspect and oversee the administration of the medication by non-medically trained designees, 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. I further agree to notify the school in writing at the termination of this request or when any change in the above orders is necessary.

_____

Possible side effects

_____

Physician/Practitioner signature

_____ _____ _____

Print signature | Clinic location | Phone

SELF ADMINISTRATION OF INHALERS:

This student has been instructed on the proper use of an inhaler and is deemed responsible to carry his/her own inhaler.

_____ _____

Physician signature | Clinic phone

PARENT/GUARDIAN SIGNATURE REQUIRED FOR ALL MEDS

- I give my permission to the designated school personnel to administer the above medication(s).
- I agree to hold the McFarland School District and the persons designated to administer the above medication harmless in any events arising from the administration of this medication.
- I agree to notify the school, in writing, of any changes in the above orders.
- I agree to keep a 30-day supply of the above medication at school and replenish as needed.
- **Medications not retrieved** by a parent/guardian within 10 days of the end of the school year **will be discarded.**
- **MEDICATIONS MUST BE SENT IN THEIR ORIGINAL CONTAINERS AND LABELED WITH:**
  1. Student's name 2. Medication name & dosage 3. Time of dose to be given 4. Physician's name

_____ _____

Parent/guardian signature | Date

_____ _____

Home/Cell Phone | Work telephone

Administer on early release days? (circle one) Y N

_____

School nurse signature

MEDICATION LOG

(Office use only)

MA Eligible?
☐ Yes ☐ No

Student Name _____ Time _____ Expiration _____

Medication Name _____ Strength _____ Dose _____ Route _____

A=Absent I=Inservice X=No School NA=None Available R=Refused Initial=Meds given w/o difficulty

	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE
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Date/Count											
Initials											

_____ Staff Initials

_____ Staff Initials

_____ Staff Initials

_____ Staff Initials