PRESCRIPTION MEDICATION CONSENT FORM

McFarland School District Health Services

Conrad Elvehjem Primary School Health Office	Waubesa Intermediate School Health Office	Indian Mound Middle School Health Office	McFarland High School Health Office
Phone: 608-838-4674	Phone: 608-838-4673	Phone: 608-838-4672	Phone: 608-838-4682
Fax: 608-838-4503	Fax: 608-838-4613	Fax: 608-838-4588	Fax: 608-838-4562

Medication Order/Consent Form may be faxed to the Student's School

STUDENT INFORMATION

Student Name _____ Date of Birth _____ Grade/School _____

Indication/Diagnosis _____ Dose _____ Route _____

Medication Name _____ Strength _____ Frequency _____

Time & Condition *(if given on as needed basis)* dose to be given _____ Start Date _____ End Date _____

PRESCRIBING PHYSICIAN/PROVIDER SIGNATURE (Required)

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 the language of the lay person.

Possible Side Effects _____ Date _____

Clinic Name/Location _____ Clinic Phone # _____

Prescribing Physician/Practitioner Name _____ Prescribing Physician/Practitioner Signature _____

❒**Yes!** This student has been instructed on the proper use of Emergency Medication (*Inhaler, Epinephrine*) and is deemed responsible to self carry their own.

Prescribing Physician/Practitioner Name _____ Prescribing Physician/Practitioner Signature _____

PARENT/GUARDIAN SIGNATURE (Required)

I give my permission to the designated school personnel to administer the above medication according to the directions provided, including on field trips. I agree to release from liability and hold the McFarland School District and its employees harmless in any and all events from the administration of this medication. I agree to notify the school, in writing, of any change in the orders. I further agree to keep the supply of the medication replenished as needed and understand only a month's supply can be stored at the school. I also give permission for the school nurse to communicate with the prescribing provider regarding this prescription. Medication must be sent in the original, LABELED MANUFACTURER OR PHARMACY CONTAINER.

Print Name _____ Preferred Phone _____

Parent/Guardian Signature _____ Date _____

Health Office Personnel Signature: _____ Date: _____