

## Medication Procedures as School

**Non-Prescription Medications:** State law requires parents/guardians to complete and sign a Medication Consent Form in order for any non-prescription (over-the-counter) medication to be administered in the school. Information required includes the student's full name, name of the medication, dose, route, frequency, time/conditions, and duration. All medication must be sent to the school office in the original manufacturer's packaging and labeled with the student's full name. This includes all over-the-counter medications such as acetaminophen and ibuprofen.

**Prescription Medications:** State law requires that a Medication Consent Form be signed by both a parent/guardian and the prescribing physician/practitioner in order to administer prescription medications to students. Information required included the student's full name, name of the medication, dose, route, frequency, time/conditions, and duration. All medication must be in the original pharmacy-labeled package with the correct prescription label attached.

For the safety of all students, no medication may be kept in the student's possession EXCEPT for the following:

- Students with asthma may possess and self-administer inhalers for the purpose of preventing or alleviating the onset of asthmatic symptoms. The student must have the Medication Consent Form with the signatures of a prescribing practitioner and a parent/guardian on file in the Health Office.
- A student with life-threatening allergies may possess and self-administer epinephrine (EpiPen) for the purpose of preventing or alleviating the onset of a severe allergic reaction. The student must have the Medication Consent Form with the signatures of the prescribing practitioner and a parent/guardian on file in the Health Office.
- Capable and responsible high school students (as determined by the parent/guardian, physician school nurse, and administrator) may possess and self-administer any medication that is not considered a controlled substance. The student must have the Medication Consent Form with signatures of the prescribing practitioner and a parent/guardian on file in the Health Office.

The school cannot provide medication for your child.

Please send only small quantities/containers of (30 tablets or less) of medication due to limited storage space.

Medication Consent Forms are available in each school office and on the district website ([www.wisheights.k12.wi.us](http://www.wisheights.k12.wi.us))



## MEDICATION CONSENT FORM

Wisconsin Heights School District

Medications are to be administered at home whenever possible. All appropriate portions of this form must be completed before medication and/or a procedure can be administered at school. **One form for EACH medication or procedure is required.**

To Be Completed by Parent

STUDENT: \_\_\_\_\_ BIRTHDATE: \_\_\_/\_\_\_/\_\_\_ GRADE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_/\_\_\_/\_\_\_

MEDICATION / PROCEDURE: \_\_\_\_\_ Physician name and phone number: \_\_\_\_\_

Name of medication or procedure needed: \_\_\_\_\_

Diagnosis or purpose: \_\_\_\_\_

Time to be given at school: \_\_\_\_\_ Or, if it is as needed, how soon may it be repeated: \_\_\_\_\_

Dates to be given at school: From (Month/Day/Year): \_\_\_\_\_ To (Month/Day/Year): \_\_\_\_\_

Dose at School: \_\_\_\_\_  
 Route: Mouth \_\_\_\_\_ Inhaled \_\_\_\_\_  
 Injected \_\_\_\_\_ Other (Explain) \_\_\_\_\_

Directions on package label: \_\_\_\_\_

Precautions/Side Effects of concern: \_\_\_\_\_

**PARENT/GUARDIAN CONSENT:** Please review each item before signing

- I understand that all medication should be delivered to and picked up from the school by a parent or guardian unless the physician indicates self-administer/ self-carry below.
- I request and authorize that school personnel administer this medication or procedure at school.
- I will supply medication in its original, dated, properly labeled container. (Request extra bottle from Pharmacist if necessary.)
- This order is in effect for this school year unless otherwise indicated.
- I will obtain a new physician's order and notify the school in writing of any changes.
- I authorize school medical personnel to exchange information verbally or in writing with my child's physician regarding this medication or the conditions for which it is prescribed. This information will be kept for 7 years beyond the child's enrollment end date.
- I will allow my child's photo to be displayed on this form. (Please consider for emergency medications.) YES \_\_\_\_\_ NO \_\_\_\_\_
- I understand that non-medical, trained school personnel will administer medication/procedure.
- I agree to hold the 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.
- My signature indicates that I have fully read and understand the above information.
- For any age student-ASTHMA INHALERS and EPI PENS ONLY: This student is capable of self-administration and may carry inhaler or EPI Pen and self-administer at school. YES NO
- Wisconsin Heights HIGH SCHOOL STUDENT NON CONTROLLED SUBSTANCES ONLY: This student is capable of self-administration and may carry any non-controlled substances and self-administer at school. YES NO  
 (REQUIRES practitioner's signature and agreement too.)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Signature of Parent/Legal Guardian      Home Phone or Cell      Business Phone      Date

**PRACTITIONER'S ORDER:** (Please complete for each medication/procedure)

The above medication/procedure is to be administered during the school day in accordance with the above instructions and agreements. I agree to accept communication about student's medication/procedure and understand non-medical, trained school personnel will administer the medication/procedure. Contact me if the following symptoms occur:

For any age student-ASTHMA INHALERS AND EPI PENS ONLY: This student and his/her parents/guardians have been instructed in self-administration and student may carry inhaler or EPI pen and self-administer at school. YES NO

Wisconsin Heights HIGH SCHOOL STUDENT NON-CONTROLLED SUBSTANCES ONLY: This student and his/her parents/guardians have been instructed in self-administration and student may carry any non-controlled substances and self-administer at school. YES NO

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Practitioner's Signature      Date      Phone

\_\_\_\_\_  
 Print Name      Clinic Name and Address      Clinic FAX#