

MEDICATION REQUEST

Winneconne School District

All portions of this Medication Request form must be completed before medication can be administered by school district personnel. If necessary, a physician's signature must also be obtained. Incomplete forms may result in the form being returned for full completion.

Student _____ School _____

Grade _____ Teacher _____

Name of Medication _____

Storage Requirements _____

Dosage _____ Time(s) to be given _____

How to be given _____

oral, injection, or other (explain)

Reason for
Medication _____

Date of
Discontinuation _____

Explain possible reactions or other instructions _____

Physician's Name _____ Physician's Phone _____

The school personnel have my permission to administer this medication as indicated above. I agree to hold the Winneconne Area School District, its employees or agents who are acting on this request, harmless in any and all claims arising from the administration of this medication at school. I also agree to inform the school immediately and in writing of any change in the medication order.

Parent/guardian signature

Date

Home Phone Number

Work Phone Number

PHYSICIAN AUTHORIZATION

The physician whose signature follows hereby authorized school personnel to administer medication as prescribed and also agrees to accept communication regarding the administration procedures. It is understood that the medication will be given by non-licensed, but specially trained personnel and *the reason(s) that the medication must be given during the school day should be given.*

Medical rationale for medication to be given during the school day: _____

Physician's signature

Phone #

Date