School District of New Glarus

453.4 Exhibit A

PRESCRIPTION MEDICATION CONSENT FORM

(Each medication requires a separate form)

TO BE COMPLETED BY THE LICENSED PRACTITIONER:

______________________________________ ____________________

____

Student's Name School Grade______________

Diagnosis

Medication____

Dose Frequency/Times_____________________________________

Start Date____________________________________Stop Date____

Possible Side Effects____

LICENSED PRACTITIONER CHECK ONE:

Prescription Medication Administered By Authorized School Personnel

______Authorized school personnel will administer this prescription medication. As the licensed practitioner, I will direct administration and am willing to accept communication from authorized school personnel**.**

Prescription Medication Is To Be Self-Administered By The Student

______This prescription medication will be self-administered. I have instructed the student in the proper method of administration (storage of medication, dosage, date(s) and time(s) to be administered, and possible side effects). In my professional opinion, this student is able to carry and self-administer the medication independently. I understand the school district does not accept any responsibility for the self-administration of prescription medication, including, but not limited to, the administration, supervision, or documentation thereof.

Licensed Practitioner's Signature_______________________________ ______________________

____________________________________Date

____

Telephone____Fax

PARENT/GUARDIAN CHECK ONE:

Prescription Medication Administered By Authorized School Personnel

______I give my permission to authorized school personnel to administer to my child the prescription medication listed above according to the licensed practitioner's directions provided on this form. I agree to hold the School District of New

Glarus and authorized staff 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 order.

Prescription Medication Is To Be Self-Administered By The Student
_______ This prescription medication will be self-administered. I have reviewed the proper method of administration (storage of medication, dosage, date(s) and time(s) to be taken, and possible side effects) with my child. I request that my child be able to carry and self-administer this medication independently. I understand the school district does not accept any responsibility for the self-administration of prescription medication, including, but not limited to, the administration, supervision, or documentation thereof.

Parent/Guardian Signature____Date______________________________

Telephone (home) ____ ______________________________
(work)

Both parent/guardian and licensed practitioner are required to sign for prescription medications.

Authorized school personnel must document medication they administer on the reverse side of this form.