Medication Request/Consent Form

Oak Creek-Franklin Joint School District, Oak Creek, WI

*Complete **one form for each prescribed medication.** Guidelines on reverse side.*

Student's First Name _____ Last Name _____
Date of Birth _____ Sex: ☐ M ☐ F
School _____ Grade _____
Parent/Guardian's Name _____ Phone# _____
Parent/Guardian's Address _____

To Be Completed by a Physician ~

☐ Refer to Asthma Management Plan
☐ Refer to IHP-Diabetes Medical Management Plan
☐ Refer to Allergy Management Plan
☐ Refer to Seizure Management Plan

Name of Medication/Treatment _____

Reason for Medication/Treatment _____

Administration Schedule (include parameters for PRN medications) _____

_____

Dose _____ Route _____

Possible Adverse Reactions/Side Effects _____

For Inhalers, Insulin, & EpiPens only: This student is both capable and responsible for self-administering this medication:

☐ No ☐ Yes, with supervision ☐ Yes, without supervision

This student **may carry Inhaler, Insulin, or EpiPen on self:** ☐ Yes ☐No

Dates Effective: From: _____ To:_____ Fax: _____

Physician's Name: _____ Phone: _____

Physician's Signature: _____ Date: _____

I, the parent or legal guardian of the above named student, have reviewed the *Administering Medicines to Students Guidelines* on the reverse side. I understand that I must submit a new request if this prescription changes. I further give permission for designated school personnel to administer the above medication to my child or for my child to self-administer this medication if applicable. This form shall also permit designated school personnel to share and request relevant health information regarding the administration of this medication. I am aware that medications are NOT given by licensed medical personnel.

Parent/Legal Guardian Signature _____ Date _____

Revision Date: 5/16/2018