ST. KATHARINE DREXEL SCHOOL
503 SOUTH SPRING STREET
BEAVER DAM, WI 53916
920-885-5558

MEDICATION CONSENT FORM

PART I - TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN

Student Name:_____School:_____Grade:_____

Parent Name:_____Phone:_____

Address:_____

Practitioner's (physician) Name:_____Phone:_____

Address:_____

I hereby give permission for school personnel to administer medication(s) to my child according to the directions stated below and authorize them to contact the practitioner if there is a question. I further authorize the practitioner to render treatment to my child, as appropriate and necessary, arising out of administration of the medication.

In the event that your child will have some unused doses of medication left on the last day of school, please advise the school on how you would like the medication returned by completing the following:

I will arrange to pick up the unused portion of my child's medication.

Please send the unused portion of my child's medication home with him/her on the last day of school.

I understand that I am responsible for making sure it arrives home safely.

_____ _____

Signature of Parent/Legal Guardian Date

PART II - TO BE COMPLETED BY PARENT/LEGAL GUARDIAN FOR NONPRESCRIPTION (OVER-THE-COUNTER) MEDICATION ONLY

Medication Name:_____Reason for Medication:_____

_____

Medication dosage, time to be given:_____

_____

School Personnel trained to distribute medication:
Ms. Barbara M. Haase, Mrs. Kathy Armstrong, Mrs. Patty Schmitt, Mrs. Rose Klavekoske, and Mrs. Judy Wilson

NONPRESCRIPTION MEDICATION must be sent to school

- in the original manufacturer's packaging
- with a list of active ingredients and
- recommended therapeutic dosage.
- The over-the-counter medication must be supplied by the parent or guardian.
- Nonprescription medication may only be administered in higher than the recommended dosage by written approval of the medical provider AND parent or guardian.

OVER

PART III – TO BE COMPLETED BY PRACTIONER FOR PRESCRIPTION MEDICATION ONLY

Student Name:_____School:_____Grade:_____

Diagnosis:_____

Medication name:_____

Medication dose, route, frequency:_____

_____

Potential adverse reactions, if known:_____

_____

Start Date:_____Stop Date:_____

Practitioner Understanding: I acknowledge by my signature on this document, that I will assist and advise non-medically trained school personnel with regard to the administration of medication described above. I further acknowledge that all instructions should be stated in language of the lay person.

_____ _____

Practitioner's Signature Date

PRESCRIPTION MEDICATION must be sent to the school

- in a pharmacy-labeled container
- with the student's full name,
- the name of prescriber,
- the name of prescription medication,
- the dose,
- the effective date, and
- the directions for administration.
- The prescription medication must be supplied by a parent or guardian.

I hereby give permission to the above named persons to give the medication(s) to my child according to the directions stated above and further authorize them to contact the child's physician. I agree to hold the School, 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.

I agree to notify the school in writing at the termination of this request or when any change in the above order is necessary.

_____

Signature of Parent / Legal Guardian Date

_____

Address

OVER