SCHOOL DISTRICT OF BARABOO
423 Linn Street
Baraboo, WI 53913
(608) 355-3950 · Fax (608) 355-3975

Consent Form for School Medication:

Medications are to be administered at home whenever possible. This includes medications that are given once daily. If it is necessary for a student to receive medications at school, all portions of this form must be completed before medication can be given at school. *One form for EACH medication is required.*

Name of Student:		Date of Birth:	
School:		Grade:	
Medication Name:		Route:	
Dose:		Frequency:	
Time(s) to be given at School:		Other Directions:	
Start Date:		End Date:	

Medication Expiration date (Cannot be expired):_____

I request and authorize that school personnel administer approved medications at school. I authorize school personnel to exchange information verbally or in writing with my child's physician regarding this medication or the conditions for which it is prescribed. I understand I may be asked to sign a release of information form for some medications to allow the school nurse to coordinate with my child's health care team. I understand that non-medically trained school personnel may give medications to my child. 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 medications at school. I understand that medication orders are in effect for the current school year only.

_____

Parent/Guardian Printed Name Relationship to student

_____

Parent/Guardian Signature Date Signed

PHYSICIAN ORDER: (required for all Prescription Medications or Dosing). This may also be on a signed physician order sheet with clinic letterhead). The above medication is to be administered during the school day in accordance with the above instructions and agreements. I agree to accept communication about student/medication and understand that non-medically trained school personnel will give the medication.

_____

Licensed Prescriber's Signature Date Signed

_____

Licensed Prescriber's Printed Name Phone Number

_____

Clinic Name

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School Medication Policy

Name: **Date of Birth** **Grade:**

PARENT/GUARDIAN CONSENT: (must complete yearly to receive medication in school).
Read and initial each area:

	Medication Necessity and Safety: I understand that parents/guardians should give medications at home, whenever possible. I understand the school district has the right to refuse giving any medications that are deemed unsafe in the school setting, such as narcotics or sedatives. I understand the school does not typically administer cold medicines or cough medicines and this should be done at home.
	No First Doses to be done at school: Due to safety reasons, I understand the school district is not able to administer the first dose of any new medications. This will be done at home or in the clinic. (Exceptions are emergency medications).
	Storage and dosing of medicine: All medication will be stored in the school health office, unless other arrangements are made with the school nurse and self-carry form is turned in. Students are not allowed to self-carry medications unless written orders are obtained from the clinic. I understand the school district cannot force my child to take medications.
	No Non-FDA approved medications: I understand the school is **not** able to administer any non-FDA approved or regulated medications. This includes: essential oils, vitamins, CBD oils, and probiotics.
	Bringing Medications to School: I will supply medications in their original, updated, properly labeled container. (Request an extra bottle from the pharmacist.) This includes any non-prescription/Over-the Counter medications. Medications turned in without correct labeling and packaging will not be given. I understand that all medication is to be transported to and from school by parent/guardian. I agree not to send in medication with my child unless other arrangements are made with the school nurse.
	Refills: I understand I am responsible for bringing in any/all refills of medications in a timely fashion. Unless prior arrangements are made with the school nurse, I will **not** send medications with my student due to safety reasons.
	Dosing Changes: I will obtain a new physician's order for any prescription medications and notify the school in writing with any changes. The school cannot give out new dosages without an official medication order change.
	End of Year Pick Up: I understand I will need to come in to pick up any remaining medication by the end of the year. The school is not responsible for storing medications over the summer. Medication that is not picked up by the last day of school will be taken to the police station for disposal, unless other arrangements are made with the school nurse.

_____

Parent/Guardian Printed Name Relationship to student

_____

Parent/Guardian Signature Date Signed