SCHOOL DISTRICT OF TOMAHAWK

PARENT - PHYSICIAN MEDICATION CONSENT FORM

District policy states that ALL prescription medication given at school, including students who carry and self-administer inhalers and Epi-pens, have-written instructions signed by the physician and the parent/guardian. No physician signature is required for OTC medication providing the dose is within the manufacturer's guidelines.

It is understood that:

1. All medications must be in an ***original over the counter (OTC) and/or pharmacy container*** with the student's name, name of medication, dose and time of administration on the label and/or container.
2. ***For students' safety***, medications sent in baggies or not in the original package will not be given by staff.
3. Students will be taken to the emergency room after using an Epi-pen or being given Glucagon.
4. Students are responsible for taking self-carried, emergency medications on field trips.
5. Students must notify a staff member if they use emergency medication(s) at school.

Name of Student:_____ Date of Birth:_____

Address:_____ Phone:_____

School:_____ Grade:_____

Medical diagnosis(es):_____

MEDICATION INSTRUCTIONS

Medication	Dosage	Frequency	Times given at home	Times given at school

Medication order effective from:_____ until:_____

Emergency Medication Administration Section: Check all boxes that apply.

Student understands the correct use of his/her emergency medication.

Student has permission to self-carry and self-administer the medication as needed at school.

- ► Epi-pen for anaphylactic life threatening reactions ☐ Yes ☐ No
- ► Inhalers for breathing emergencies. ☐ Yes ☐ No

PHYSICIAN-PARENT CONSENT

Physician's signature authorizes staff to give the listed medication to my son/daughter. I hereby give permission to the staff designated by school principal or district nurse to give the above medication to my son/daughter according to the instructions stated above and authorize them to contact the physician if necessary. A new form is needed when there are changes In the dose of medication or if the medication is discontinued. Consent is valid for the current school year.

Physician's name, address, phone

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_____

_____

_____

_____ _____

Physician's Signature Date

_____ _____

Parent/Guardian Signature Date