

**MEDICATION REQUEST/CONSENT FORM**  
**School District of Beloit, Beloit, Wisconsin**

Medications are encouraged to be administered at home by their parent/guardian whenever possible. If it is necessary for a student to receive medications at school, on field trips, or a school sponsored activity, all appropriate portions of this form must be completed before medication can be given at school. One form for EACH medication is required.

**This section to be completed by the Parent/Guardian:**

Student: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
School: \_\_\_\_\_ Grade: \_\_\_\_\_  
Physician Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**Parent/Guardian Consent:**

- I request and authorize that school personnel administer this medication/procedure at school.
- I will supply medication in its original, updated, pharmacy/manufacture labeled container. (Request extra bottle from pharmacy).
- This order is in effect for the current school year unless otherwise indicated.
- I will obtain a new physician's order and notify the school with any changes in the medication (dosage, time, route).
- I authorize the principal, assistant principal, or the school nurse to exchange information verbally or in writing with my child's Physician/Practitioner regarding this medication for any medication related concerns.
- I understand that all medication is to be transported to and from school by parent/guardian.
- 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 this medication at school.
- My signature indicates that I have fully read and understand the above information.

**ASTHMA INHALERS ONLY:** My child is capable of self-administration and may carry an inhaler and self-administer in school.  Yes  No

**EPIPENS (Epinephrine auto-injector) ONLY:** My child is capable of self-administration and may carry an EpiPen and self-administer in school.  Yes  No

My child attends Beloit Memorial High School and may carry and self-administer medication in school.  Yes  No

Parent/Guardian Signature: \_\_\_\_\_ Phone: \_\_\_\_\_

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**This section to be completed by Physician/Practitioner:**

Name of Medication or Procedure: \_\_\_\_\_

Reason for Medication or Procedure: \_\_\_\_\_

Method:  Oral  inhaled  nebulizer  injectable  G-tube  rectal  topical  eye  ear other: \_\_\_\_\_

Time to be given: \_\_\_\_\_ Dose: \_\_\_\_\_  Daily  As needed

This permission is valid for:  Current School Year OR Dates: From \_\_\_\_\_ To \_\_\_\_\_

**ASTHMA INHALERS ONLY:** This student is capable of self-administration and may carry an inhaler and self-administer in school.  Yes  No

**EPIPENS (Epinephrine auto-injector) ONLY:** This student is capable of self-administration and may carry an EpiPen and self-administer in school.  Yes  No

This student attends Beloit Memorial High School and may carry and self-administer medication in school.  Yes  No

The above medication is to be administered during the school day in accordance with the above instruction and agreements. I agree to accept communication about student/medication and understand that designated school personnel will give the medication. Please contact me if the following symptoms occur: \_\_\_\_\_

\_\_\_\_\_  
Physician/Practitioner Signature

\_\_\_\_\_  
Date:

\_\_\_\_\_  
Printed Name & Address of Physician/Practitioner & Phone Number

# SOLICITUD DE MEDICAMENTOS Y FORMULARIO DE CONSENTIMIENTO

## Distrito Escolar de Beloit, Beloit, Wisconsin

Se promueve que los medicamentos sean administrados en el hogar por los padres / guardianes cuando sea posible. Si es necesario que un estudiante reciba medicina en la escuela, en los paseos, o una actividad patrocinada por la escuela, se requiere que todas las partes apropiadas de este formulario sean completadas antes de que el medicamento pueda ser administrado en la escuela. Se requiere UN formulario por CADA medicamento.

### Esta sección debe ser completada por el Padre o Tutor:

Estudiante: \_\_\_\_\_ Fecha de Nacimiento: \_\_\_\_\_ Fecha: \_\_\_\_\_

Domicilio: \_\_\_\_\_ Teléfono: \_\_\_\_\_

Escuela: \_\_\_\_\_ Grado: \_\_\_\_\_

Nombre del Médico: \_\_\_\_\_ Dirección: \_\_\_\_\_ Teléfono: \_\_\_\_\_

### **Consentimiento del Padre o Tutor:**

- Yo solicito y autorizo que el personal de la escuela administre este medicamento o procedimiento en la escuela.
- Yo suministraré el medicamento en su envase original, actualizado, con el envase etiquetado de la farmacia y fabricante. (Solicite un envase adicional en la farmacia).
- Esta orden está en vigor para el año escolar actual, al menos que se indique lo contrario.
- Yo obtendré una nueva receta del médico y notificaré a la escuela con cualquier cambio en la medicación (dosis, tiempo, método).
- Yo autorizo al director, subdirector, o la enfermera escolar a intercambiar información verbalmente o por escrito con el medico de mi hijo con respecto a este medicamento o cualquier duda relacionada con este medicamento.
- Yo entiendo que todos los medicamentos tienen que ser llevados y recogidos a la escuela por el padre o tutor.
- Yo estoy de acuerdo en eximir al Distrito Escolar, sus empleados, y agentes que están actuando dentro del ámbito de sus funciones, libremente de cualquiera y todas demandas o reclamos derivadas en la administración de este medicamento en la escuela.
- Mi firma indica que he leído y comprendo completamente la información escrita arriba.

**SOLAMENTE para INHALADORES de ASMA:** Mi hijo es capaz de administrarse y puede poseer personalmente un inhalador y administrarse el inhalador en la escuela:  Sí  No

**SOLAMENTE para EPIPENS (Epinefrina-inyectado personal):** Mi hijo es capaz de administrarse y puede poseer personalmente un EPIPEN y administrarse (inyectarse) el EPIPEN en la escuela:  Sí  No

Mi hijo asiste en Beloit Memorial High School y puede llevar consigo y administrarse el medicamento en la escuela:  Sí  No

Firma del padre o tutor: \_\_\_\_\_ Teléfono: \_\_\_\_\_

### **This section to be completed by Physician/Practitioner:** (Esta Sección tiene que ser completada por el Doctor o Médico)

Name of Medication or Procedure: \_\_\_\_\_

Reason for Medication or Procedure: \_\_\_\_\_

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Physician/Practitioner Signature

Date:

Printed Name & Address of Physician/Practitioner & Phone Number