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 mediations 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: _____ Clinic (name, city): _____ 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/manufacturer 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 health office 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 at school. ☐ Yes ☐ No

My child is responsible and may carry their inhaler on them at school. I will take responsibility for any actions that may result from this. ☐ Yes ☐ No

My child requires pre-activity treatment, including before gym/recess: ☐ 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

Parent/Guardian Signature:_____ Date: _____

This section to be completed by Physician/Practitioner:

Name of Medication or Procedure: _____

Reason for Medication or Procedure:_____

Method: ☐ Oral ☐ inhaled ☐ nebulizer ☐ IM ☐ Sub-Q ☐ G-tube ☐ rectal ☐ topical ☐ eye ☐ ear other: _____

Time/Frequency 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 at school. ☐ Yes ☐ No
The student is responsible and may able to carry their inhaler on them at school. ☐ Yes ☐ No

The student requires pre-activity treatment, including before gym/recess: ☐ 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

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 / Clinic Name and 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: _____ Clínica (nombre, cuida): _____ 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 su inhalador: ☐ Sí ☐ No
Mi hijo es responsable y puede llevar su inhalador en la escuela. Me haré responsable de cualquier acción que pueda resultar de esto: ☐ Sí ☐ No
Mi hijo requiere tratamiento previo a la actividad, incluso antes del gimnasio / recreo: ☐ 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

Firma de 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: _____

Method: ☐ Oral ☐ inhaled ☐ nebulizer ☐ IM ☐ Sub-Q ☐ G-tube ☐ rectal ☐ topical ☐ eye ☐ ear other: _____

Time/Frequency 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 at school. ☐ Yes ☐ No
The student is responsible and carry their inhaler on them at school. ☐ Yes ☐ No
The student requires pre-activity treatment, including before gym/recess: ☐ 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

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 / Name of Clinic and number