SCHOOL DISTRICT OF WESTFIELD
Medication Administration Request/Consent Form

Student Name: _____ DOB: _____

School: ▢ WES ▢ OES ▢ CES ▢ WMS ▢ WHS Grade: _____

Name of Medicine: _____

Form of Medicine: ▢ Tablet/Capsule ▢ Liquid ▢ Inhaler ▢ Injection ▢ Other _____

Route of Delivery: ▢ By Mouth ▢ Topical ▢ Inhaled ▢ Injected ▢ Other _____

Dose and Frequency (example - one 5 mg tablet twice daily at 10 am and 2 pm):

_____

Time(s) to Be Given at School: _____ OR AS NEEDED (PRN)

Dates To Be Given: _____ to _____ OR 8/1/2024 to 7/31/2025 (limit of one school year)

For Prescription Medications, Reason/Condition for Medication: _____

For As Needed (PRN) Medications, describe symptoms or conditions for which medication is to be given:

_____

PARENT/GUARDIAN REQUEST/CONSENT

I hereby authorize the School District of Westfield to give medication(s) to my child according to the directions stated above and further authorize the School District to contact my child's physician. 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. I also agree to inform the school immediately, in writing, of any change of medication order. I agree to obtain a new physician's order for any changes to prescription medication's dose, time, etc.

I will supply limited quantities of the medication in the **original, labeled, unopened container, with the child's full name, name of drug and dosage, time and quantity to be given and the physician's name.**

I agree to drop off the medication at my child's school office. I agree not to send any medication to school with my child. I agree to pick up the medication either at the end of the school year (or at the end of summer school if my child attends summer school); and I acknowledge that the medication will be disposed of properly by the school nurse if I fail to pick up the medication at this time. I acknowledge that the school is not responsible for storing medications over the summer.

*** ONLY FOR EPINEPHRINE OR RESCUE ASTHMA INHALER, check if applicable: ▢ I request that my child be permitted to carry and self-administer the above ordered medication. I take responsibility for this permission.*

_____	_____	_____	_____
Signature of Parent/Legal Guardian	**Print Name**	**Date**	**Phone Number**

PHYSICIAN'S ORDER (ONLY NEEDED FOR PRESCRIPTION MEDICATION OR IF NOT FOLLOWING LABELED DOSE, ETC)

The physician whose signature is shown below orders the administration of the medication as prescribed above, agrees to accept communication about student/medication, & understands that medication will be given by non-medically trained school personnel.

*** ONLY FOR EPINEPHRINE OR RESCUE ASTHMA INHALER, check if applicable: ▢ In my opinion, the student shows the capability to carry and self-administer the above ordered medication. I take responsibility for this permission.*

_____	_____	_____	_____	_____
Provider/Physician Signature	**Print Name**	**Date**	**Phone Number**	**Fax Number**

Wisconsin Law 118.291 and 118.292 permits a responsible, trained student to carry and/or self-administer medication for asthma or severe allergic **(anaphylactic) reaction on his/her person for immediate use in a life-threatening situation with written order of physician, parent request, and school nurse approval. Rev. 6/2021

Physician's signature on prescription consent may be faxed to your child's school. Fax numbers listed below: WES: 608-296-4001 OES: 608-586-4521 CES: 715-228-2860 WMS/WHS: 608-296-2293	**STAFF ONLY:** ▢ Med received and matches form ▢ Med entered in Skyward ▢ Exp Date & Age Restrictions Checked ▢ Form sent to Nurse ▢ Needed Signatures Checked ▢ Form uploaded to Skyward