SCHOOL DISTRICT OF BELLEVILLE

Belleville, Wisconsin 53508 | 608.835.6120 | www.belleville.k12.wi.us

MEDICATION ADMINISTRATION CONSENT FORM

STUDENT NAME: _____ **DOB:** _____

==========

NON-PRESCRIPTION (OVER-THE-COUNTER) MEDICATION PORTION: ***(MD signature NOT required)***

Medication: _____ **Dosage:** _____ **Frequency:** _____ **Reason:** _____

Medication: _____ **Dosage:** _____ **Frequency:** _____ **Reason:** _____

Medication: _____ **Dosage:** _____ **Frequency:** _____ **Reason:** _____

☐ **My child can carry/self-administer the above medication**

==========

PRESCRIPTION MEDICATION PORTION ONLY: ***(To be completed by a MD / PA /NPAP Only)***

Medication: _____ **Dose:** _____ **Time:** _____

Route: _____ **Reason:** _____ **Side Effects:** _____

Medication: _____ **Dose:** _____ **Time:** _____

Route: _____ **Reason:** _____ **Side Effects:** _____

Medication: _____ **Dose:** _____ **Time:** _____

Route: _____ **Reason:** _____ **Side Effects:** _____

==========

EMERGENCY MEDICATION MANAGEMENT (Asthma Inhalers / Epi-Pens / Glucagon/BAQSIMI) :

Student _____CAN _____CANNOT carry & self-administer the prescribed RESCUE INHALER
Student _____CAN _____CANNOT carry & self-administer the prescribed EPIPEN
Student _____CAN _____CANNOT carry & self-administer the prescribed GLUCAGON/BAQSIMI

Parent / Guardian Authorization:

I, the parent/guardian of the above named student, have read the school's medication policy & request the medication listed below to be administered to my child at school. I agree to hold the School District of Belleville, its officers, 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 to my child. I understand that a qualified, designated person will be administering the medication & that I am responsible for maintaining a sufficient quantity at school to avoid interruptions with the MD orders. *I understand that I am responsible for bringing the medication to school in* ***its original, updated, properly labeled container.*** I understand that if my child refuses a prescription drug, force will not be exerted by school personnel to make them comply. I will notify the school immediately if there is a change or cancellation of the medication. The school district has my permission to contact the prescriber in regard to medications that are prescribed.

Parent / Guardian Signature: _____ **Date**: _____

Medical Provider Signature: _____ **Date**: _____

Belleville District Nurse Signature: _____ **Date**: _____