ELMBROOK SCHOOLS
School District of Elmbrook

School Nurse Approval/Comments: _____

_____

Student Name: _____ School: _____

Birthdate: _____ Grade/Teacher/House: _____

Home Phone: _____ School Fax: _____

PARENTAL CONSENT FOR OVER-THE-COUNTER AND PRESCRIPTION MEDICATIONS

Name of Medication	Dosage	Time AM/PM	Reason
1.			
2.			
3.			

I give consent for school personnel to administer the above listed medication/s. I agree to notify the school in writing at the termination of this request or when any changes in the above order is necessary. I understand that all unused medication will not be returned to my student. Parents must come to the Health Room for unused medication or it will be disposed of. The District reserves the right to contact the physician regarding administration of this medication.

_____ _____/_____/_____
Signature of Parent/Guardian *Date*

PRESCRIPTION MEDICATION/S

Note: Before medication(s) prescribed by a physician can be administered by school personnel, a signed statement from the physician which includes (a) the conditions and circumstances for administering the medication(s), (b) the prescribed dosage, and (c) the frequency of administration, must be on file. The "Physician Order for Medication" (below) may be used for this purpose.

I am prescribing medication for_____who has a diagnosis of_____

_____.

Name of Medication	Dosage	Time AM/PM	Side Effects
1.			
2.			
3.			

→ _____ Date_____/_____/_____
SIGNATURE OF PHYSICIAN OR OTHER HEALTH CARE PROVIDER WITH PRESCRIPTIVE RIGHTS

Physicians Address:_____ Phone:_____Fax:_____

APPROVAL FOR STUDENT CARRYING INHALER

This patient has received instruction and has demonstrated competency in the use of a metered dose inhaler. He/she may carry and self-administer the inhaler as prescribed. Yes_____ No_____

→ _____ Date_____/_____/_____
SIGNATURE OF PHYSICIAN OR OTHER HEALTH CARE PROVIDER WITH PRESCRIPTIVE RIGHTS