Parent/Guardian Prescription Medication Consent Form

(Please type or print)

Full name of child to be medicated: _____

Name of drug and dosage: _____

Hour(s) medication to be given:_____Number of Days:_____

Name of physician prescribing medication: _____ Phone:_____

Reason for medication: _____

_____

School Administrative Assistant administering medication: _____

_____

I hereby give permission to the above named persons to give the medication(s) to my child according to the directions stated above and further authorize them to contact the child's physician.

I agree to hold the School, 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 agree to notify the school in writing at the termination of this request or when any change in the above order is necessary.

_____ _____

Signature of Parent/Legal Guardian Date

_____

Address

Form

5140.2(a)

2015-2016

Catholic East Elementary School
Release Form for Students Who Use an Inhaler

Please ensure that all signatures necessary to implement this "Inhaler Use" form are in place on this form before submitting it to the school office. If your child uses an inhaler, we must have this form on file.

Date:_____

1. (Student name)_____ has been instructed in the

proper use of inhaler listed here:_____

2. We, _____ and _____
(Physician) (Parent/Legal guardian)

request that (Child's Name:)_____ be permitted to carry the inhaler on his/her person, or to keep same in his/her classroom or locker, as we consider this student to be responsible.

He/she has been instructed in, and understands the purpose and appropriate method and frequency of use of the inhaler.

We, the undersigned physician and parent/legal guardian absolve the school and its employees, agents and officers of any responsibility in safeguarding our child's inhaler.

_____ _____
(Parent/Legal Guardian's Signature) (Date)

_____ _____
(Physician's Signature) (Date)

Please return this form to the school office by September 2, 2015

ARCHDIOCESE OF MILWAUKEE

Form
5140.2 (a)

Parent(s)/Guardian Medication Authorization Form
Nonprescription Medication

Student's Name: _____ Date of birth: _____

School: _____ Grade: _____

Diagnosis: _____

As the parent and guardian of the above mentioned student, I give the school permission to administer the following medication(s) to my child for the diagnosis/reason listed above:

Medication Name	Dosage: mg, cc, ml, etc	Route: How it is to be given	Frequency: How often	Start Date	Stop Date	Side Effects
1.						
2.						
3.						

As the parent or guardian of the above mentioned student, I will keep the school aware of any changes in medication(s) profile or health concern of my child.

As a part of the Wisconsin Statute Chapter 118.29, schools are required to have permission from a parent/guardian to administer nonprescription medications at school. As part of this authorization form, school employees may contact the medical provider with questions regarding the medication administration including clarification regarding dosage, side effects or indication of the medication(s) listed above with parent permission.

All medications must be in the original container listing the recommended therapeutic dosage. Administration of a dosage other than the recommended therapeutic dose may be given only if the written request to do so is also accompanied by the written approval of the child's medical provider.

Parent(s) Guardian Signature: _____ Date: _____

2015-2016

Form

5140.2(b)

TO BE FILLED OUT BY PHYSICIAN

Please administer the following medication(s) to:

Name of Student_____ Address_____

Student Phone Number_____School:_____Grade_____

Diagnosis_____

Physician Medication Orders_____

DAILY MEDICATIONS

Medicine	Route	Dose	Frequency	Duration	Direct contact shall be made with me should the student receiving the medication develop any of the following conditions or reactions to the medication: (if none, so state).
				From: To:	
				From: To:	
				From: To:	

PRN MEDICATIONS (as is needed)

Medicine	Route	Dose	Frequency	Duration	Direct contact shall be made with me should the student receiving the medication develop any of the following conditions or reactions to the medication: (if none, so state).
				From: To:	
				From: To:	
				From: To:	

I agree to retain the power to direct, supervise, decide, inspect and oversee the administration of such medication(s). Direct contact shall be made with me at any time should you have any questions.

Hospital/Clinic/Office:_____ Phone:_____

Address:_____

Physician's Signature:_____ Date:_____

2015 - 2016

Must be completed for all students with serious medical conditions

CATHOLIC EAST ELEMENTARY SCHOOL
SERIOUS MEDICAL CONDITIONS FORM

Your child's health and well-being are very important to us. By completing the STUDENT CARE PLAN helps ensure that your child will be given the best possible care should the need arise.

PLEASE PRINT OR TYPE

STUDENT NAME:_____**Grade**_____

CONDITION:_____

SYMPTOMS:

_____

_____

_____

WHAT SHOULD WE DO IF SYMPTOMS ARISE:

_____
_____
_____
_____

WHAT SHOULD WE NOT DO:

_____
_____
_____
_____
_____

ANY FURTHER COMMENTS:

_____
_____
_____
_____
_____

***** MEDICATIONS TO BE TAKEN AT SCHOOL:**

DIRECTIONS FOR ADMINISTRATION OF MEDICATIONS:

LIST POTENTIAL ADVERSE REACTIONS TO MEDICATIONS:

WHAT SHOULD WE DO IF AN ADVERSE REACTION OCCURS:

***** Please note that the attached Physician Request and Authorization must be completed for each medication you request be taken by your child during school hours.**

2015-2016

Please return form to the school office by September 2, 2015