SCHOOL DISTRICT OF WISCONSIN DELLS
CONNECT ✦ INSPIRE ✦ ACHIEVE
Everyone. Every day.

MEDICATION REQUEST/CONSENT FORM

Medications are to be given at home whenever possible. If it is necessary for a student to receive medications at school, all appropriate portions of this form must be completed before medication can be given at school. Incomplete forms may result in the form being returned for full completion. Parents may administer needed medications to their child at school until requirements are met.
One form is required for **EACH** medication.

- All prescription medications require **BOTH** a health provider signature and a parent/guardian signature.
- All over-the-counter medications require **ONLY** a parent/guardian signature, unless medication exceeds the manufacturers recommended packaging dose, in which case a healthcare provider signature is also required.
- All medications must be brought in the original pharmacy/manufacturer labeled container by parent/guardian. Medication will not be able to administered without this.

Student: _____ **DOB:**_____ **Grade:**_____

School: **WDHS**_____ **WDMS**_____ **SHE**_____ **LDE**_____

Healthcare Provider:_____ **Clinic:**_____ **Phone:**_____

Parent/Guardian:_____ **Phone:**_____ **Alt:**_____

MEDICATION/PROCEDURE

EFFECTIVE DATE: 2025-2026 School Year

Name of Medication or Procedure: _____

Reason for Medication/Procedure (Diagnosis):_____

Route to be given: ( ) **oral** ( ) **inhaled** ( ) **injectable** ( ) **topical** ( ) **eye** ( ) **ear** ( ) **other**_____

Dose at school :_____Time(s) to be given at school: _____

PARENT/GUARDIAN CONSENT: (Review each item before signing)

- I understand that all medication is to be delivered to the school and picked up from the school by parent/guardian/ responsible adult unless the healthcare provider below indicates that student may self carry, self-administer medication.
- I will supply medication in it's original, dated, properly labeled container. (request extra bottle from the pharmacy)
- I understand that this order is in effect for the current school year only, unless otherwise indicated.
- I request and authorize that school personnel administer this medication or perform this procedure at school.
- I will obtain a new Physician's order and notify the school in writing for any changes.
- I authorize school personnel to exchange information verbally or in writing with my child's healthcare provider regarding this medication/procedure or the conditions for which it is prescribed.
- I understand that non-medical, trained school personnel will be administering medications & performing procedures.
- I understand that I am responsible to assure that backup rescue medication is available to my child outside of school hours and traveling to/from and during school-sponsored events.
- I agree to hold the School District of Wisconsin Dells, 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/procedure at school.
- **For any age student: ASTHMA INHALERS, GLUCAGON & EPIPENS ONLY**

This student is capable of self-administration & may carry an inhaler, glucagon or EPIPEN & self-administer in school. **( ) YES ( ) NO**

- My signature indicates that I have fully read and understand the above information.

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

PHYSICIAN ORDER: (Complete for EACH Medication/Procedure):

The above medication/procedure is to be administered during the school day in accordance with the above instructions and agreements. I agree to exchange information verbally or in writing about the student/medication/procedure and understand that non-medical, trained school personnel will administer the medication/procedure.

Contact me if the following symptoms occur:_____

SELF CARRY, SELF ADMINISTER:

For any age student: ASTHMA INHALERS, GLUCAGON & EPIPENS ONLY

This student and their parents/guardians have been instructed in self-administration and student may carry an inhaler, glucagon or EPIPEN & self-administer in school. **( ) YES ( ) NO**

_____ _____ _____
Signature of Licensed Healthcare Provider **Phone Number** **Fax Number**

_____ _____
Printed Name **Date**