

School District of Fort Atkinson
Administering Medication to Students

(Please return to your child's school)

2013-2014

Student Name _____

Physician's Name _____

Birthdate _____ Male _____ Female _____

Physician's Address _____

School _____ Grade _____

Teacher (if applicable) _____

Physician's Phone _____

Parent/Guardian _____

Physician's Fax _____

Home Phone _____ Work Phone _____

Cell Phone _____

To Parent/Guardian/Physician:

The School District of Fort Atkinson is required by state statute to give prescription medication to students only with the complete directions from a physician and signed consent by parent/guardian. Medication must be supplied in the original container or packaging. For safety and liability reasons, medication received in any container other than the original will not be acceptable for staff administration. By signing this form, you release the Board of Education, its agents and employees from any and all liability which may result from taking this medication.

*One medication per form

Medication _____ Dosage _____ Frequency _____

Start Date _____ End Date _____
End of School Year (EOSY) = July 30

Form: Tablet/Capsule Liquid Inhaler Nebulizer Injection

For episodic/emergency events only other _____

*Emergency Medications (inhaler, glucagon, insulin, epi-pen). Student to self-administer/carry: Yes No

Time(s) to be given _____ Reason for this medication _____

If given on an "as needed" basis, please describe _____

Special instructions _____

Side effects (expected or predictable) _____

Physician's Signature _____ **Date** _____

(Signature required for all prescription medication and for non-prescription medication that exceeds the manufacturer's recommended dosage.)

Parent/Guardian Signature _____ **Date** _____

(Signature required for all prescription and nonprescription medication).