SCHOOL DISTRICT OF HARTFORD Jt. #1

PRESCRIPTION MEDICATION PERMISSION FORM

Use a separate form for each medication.

All medication must be brought in by the parent/guardian in its current pharmacy labeled container.

Central Middle School
1100 Cedar Street
Hartford, WI 53027
Phone: 262-673-8040
Fax: 262-673-7596

Lincoln Elementary School
755 S. Rural Street
Hartford, WI 53027
Phone: 262-673-2100
Fax: 262-673-0148

Rossman Elementary School
600 Highland Avenue
Hartford, WI 53027
Phone: 262-673-3300
Fax: 262-673-3543

Date form received by the school _____

Student's Name_____ D.O.B./Age_____ Grade_____ Teacher_____

Principal's Signature _____

This section to be completed by physician or authorized prescriber.

Name of medication (please print):_____

Reason for medication:_____

Form of medication/treatment (please check proper box)

☐ Tablet/Capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other

Instructions (schedule and exact dose to be given at school):_____

_____

Duration: From _____ to _____

Restrictions and/or important side effects: ☐ None anticipated ☐ Yes. Please describe:_____

_____

Special storage requirements: ☐ None ☐ Refrigerate ☐ Other: _____

Additional information for use of INHALERS / EPI PENS / GLUCAGON / INSULIN

Level of independence recommended for this student:

- This student is both capable and responsible for self-administering this medicine
  ☐ No ☐ Yes, supervised ☐ Yes, unsupervised
- This student may carry this medicine ☐ No ☐ Yes
- Other (attach additional information if necessary) _____

Physician:_____ Clinic:_____

Address:_____ Phone Number:_____

Physician's Signature:_____ Fax Number:_____

***School personnel should report concerns about this medication or related health issues to the student's physician.**

PARENT/GUARDIAN CONSENT FORM

I hereby give permission for (name of child) _____to receive medication at school according to School District Policy JHCD. I also authorize the District designated personnel to give 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 District of Hartford Jt. #1, its employees and agents who are acting within the scope of their duties harmless (Wisconsin Statutes 118.29). I also agree to notify the school in writing in the event that any change(s) in the administration of this medicine occur.

Signature of Parent/Guardian:_____ Date:_____

Name ______________________________

INITIALS AND SIGNATURE OF PERSON ADMINISTERING MEDICATION		KEY	
Initials	Signature	A – Absent	R – Refuse to take
		D – Early dismissal	W – Dose withheld
		F – Field trip	X – Out of meds
		O – Other	

CONTROLLED SUBSTANCE - TOTAL OF MEDICATION RECEIVED			
Date	No. of Pills	Staff Signature	Parent Signature

MEDICATION ADMINISTRATION								
Date	Time/Key	Initials	Date	Time/Key	Initials	Date	Time/Key	Initials