

# Parental Permission to Administer Medication Chippewa Falls School District

## I. Student Information/ Medication Instructions:

School Year or Effective Date \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_  
(Start – End)

Student's Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
(PLEASE PRINT)

Medication \_\_\_\_\_ Dosage \_\_\_\_\_ Time \_\_\_\_\_ Route \_\_\_\_\_

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Medication \_\_\_\_\_ Dosage \_\_\_\_\_ Time \_\_\_\_\_ Route \_\_\_\_\_

Reason for Medication \_\_\_\_\_

### Note requirements:

For **prescription** medication:

Signed **Physician Order (2)** and signed **Parent Consent (3)**

For **non-prescription** medication:

Signed **Parent Consent (3)**

## 2. Physician Order: Complete for **Each Prescription Medication** at school

This medication is to be administered during the school day in accordance with the instructions Listed in #1.

Please contact me if the following symptoms occur: \_\_\_\_\_

Asthma inhalers **ONLY** : Student may carry inhaler in school. Yes/No

Date \_\_\_\_\_ Physician's Signature \_\_\_\_\_ Telephone Number \_\_\_\_\_

## 3. Parent Consent: Complete for **Each Medication** at school.

I request that this medication be administered at school by the designated employee.

I will supply the medication in its original, properly labeled pharmacy container.

I will count the medication and will notify the school of the amount being sent.

I will notify the school **in writing** of any medication changes and will obtain a new physician's order.

I authorize school personnel to contact my child's physician if needed.

This consent is in effect for the school year unless otherwise indicated.

Date \_\_\_\_\_ Parent/Guardian Signature \_\_\_\_\_

Telephone (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_ (Work) \_\_\_\_\_