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_____

Medication_____Dosage_____Time_____Route_____

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)_____

MEDICATION EXPIRATION DATE:_____ **IC** _____ **Copy for file** _____