NORTHLAND PINES SCHOOL DISTRICT
PHYSICIAN AND PARENT REQUEST FOR SCHOOL ADMINISTRATION OF PRESCRIPTION MEDICATION
(Wisconsin Statute 118.29)

Student_____ Date of Birth_____

School_____ Grade_____ Teacher/Advisory_____

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED HEALTH CARE PROVIDER

Name of Medication_____

Dosage:_____ Time(s) to be given:_____

If "as needed" circumstances when medication is to be given _____

Tablet/capsule_____ liquid_____ inhaler_____ injection_____

nebulizer_____ other_____

Duration: ☐ Remainder of School Year ☐ Other_____

Reason for Medication_____

Restrictions and/or important side effects:_____

Special storage requirements: __None _____Refrigerate _____Other_____

FOR INHALED OR INJECTED MEDICATION ONLY:
This student is both capable and responsible for self-administering this medication:
_____Yes – Supervised _____Yes – Unsupervised _____ No reason/restrictions _____

This student may carry their inhaler/injectable medication while at school: _____Yes _____No

The physician/health care provider whose signature follows hereby authorizes school personnel to administer medication/treatment as prescribed and also agrees to accept communication regarding the administration procedures. It is understood that non-licensed, trained personnel will give the medication/treatment and the provider gives the reason why the medication/treatment must be given during the day. The student per section 118.291(Wis. Stats.) may carry prescription inhalers with written signature from the physician/nurse practitioner and the student's parent/guardian.

_____ _____ _____
Physician's Signature Printed Name Date

_____ _____
Phone Number Mailing Address

TO BE COMPLETED BY PARENTS/GUARDIAN
The school personnel have my permission to administer this medication/treatment as indicated above. I agree to hold the Northland Pines School District, its employees and agents who are acting on this request, harmless in any and all claims arising from the administration of this medication/treatment at school. I shall pick up unused portions of the medication within three (3) days of completion of the school year or when discontinued. I acknowledge that the medication will be destroyed if it has not been picked up after a ten (10) day period following notification. I agree to notify the school in writing at the termination of this request. If any change in the above order is necessary, parent and physician must complete a new form.

I hereby give my permission for the School District of Northland Pines to contact the physician/health care provider listed above to contact the physician with questions as they arise regarding the administration of this medication.

_____ _____
Signature of Parent/Legal Guardian Date

_____ _____
Home Phone Number Work Phone Number

Revised 08/30/12