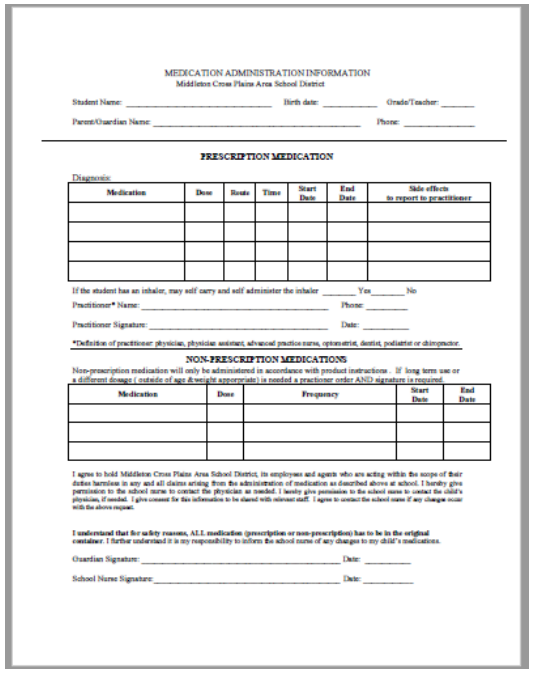
PRESCRIPTION MEDICATION FOR SCHOOL:

What You'll Need



MEDICATION ADMINISTRATION INFORMATION
Middleton Cross Plains Area School District

Student Name: _____ Birth date: _____ Grade/Teacher: _____

Parent/Guardian Name: _____ Phone: _____

PRESCRIPTION MEDICATION

Diagnosis:

Medication	Dose	Route	Time	Start Date	End Date	Side effects to report to practitioner

If the student has an inhaler, may self carry and self administer the inhaler _____ Yes _____ No

Practitioner* Name: _____ Phone: _____

Practitioner Signature: _____ Date: _____

*Definition of practitioner: physician, physician assistant, advanced practice nurse, optometrist, dentist, podiatrist or chiropractor.

NON-PRESCRIPTION MEDICATIONS

Non-prescription medication will only be administered in accordance with product instructions. If long term use or a different dosage (outside of age &weight appropriate) is needed a practioner order AND signature is required.

Medication	Dose	Frequency	Start Date	End Date

I agree to hold Middleton Cross Plains Area School District, its employees and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of medication as described above at school. I hereby give permission to the school nurse to contact the physician as needed. I hereby give permission to the school nurse to contact the child's physician, if needed. I give consent for this information to be shared with relevant staff. I agree to contact the school nurse if any changes occur with the above request.

I understand that for safety reasons, ALL medication (prescription or non-prescription) has to be in the original container. I further understand it is my responsibility to inform the school nurse of any changes to my child's medications.

Guardian Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____

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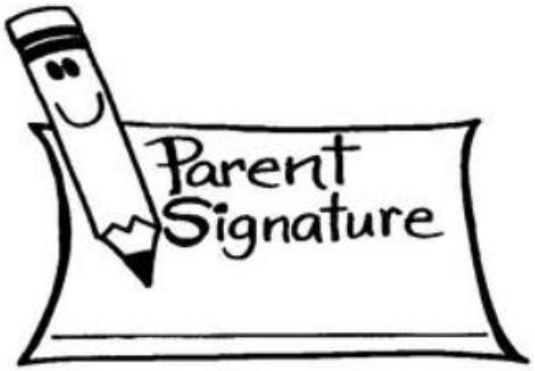

MEDICATION FORM *(On district website)*	**MEDICATION** *(In original pharmacy container with prescription label)*	**PARENT/GUARDIAN SIGNATURE**
Fill out the top half of the form. A physician needs to sign and date the form. **Note:** School *will* accept other forms as long as all pertinent information is provided.	The prescription label instructions need to match the instructions listed on the medication form.	Sign and date bottom of the medication form.

Medication Form:

http://www.mcpasd.k12.wi.us/sites/www.mcpasd.k12.wi.us/files/content/node/280/health-forms-and-downloads/medicationadmininfo.pdf