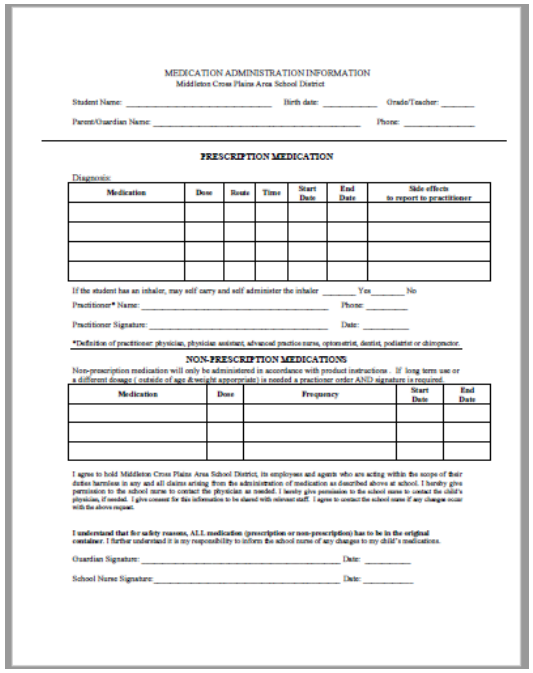
MEDICAMENTO CON RECETA EN LA ESCUELA:

Lo que necesitará



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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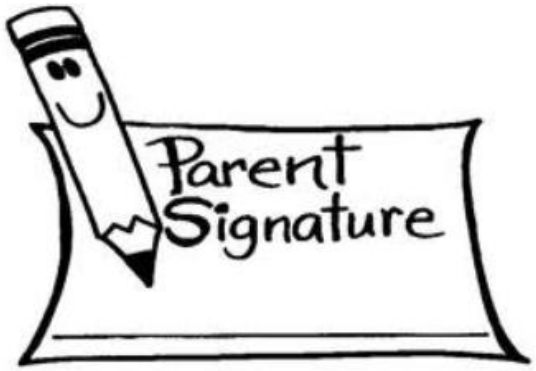

FORMA DE MEDICAMENTO *(En el sitio web del distrito)*	**MEDICAMENTO** *(En el contenedor original de la farmacia con la etiqueta de la receta)*	**FIRMA DE PADRE/MADRE/TUTOR**
Complete la primera mitad de la forma. Un doctor necesitará firmar y poner fecha en la forma. **Nota:** La escuela aceptará otras formas si se proporciona toda la información pertinente.	Las instrucciones de la etiqueta con la receta necesita ser la misma que las instrucciones listadas en la forma de medicamento.	Firme y escriba la fecha en la parte inferior de la forma.

Forma de medicamento:

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