OCONOMOWOC AREA SCHOOL DISTRICT
EMPOWERING A COMMUNITY OF LEARNERS AND LEADERS

District Nurse Phone: 262-560-2104
District Nurse Fax: 262-560-2106

PARENT/ PHYSICIAN CONSENT FORM FOR MEDICATION ADMINISTRATION

Name of Student:	**DOB**:	**School**:
Diagnosis:		
Physican Name:	**Physician Phone:**	**Physician Fax:**

Medication	**Route**	**Dose**	**Time**	**Duration**

- I hereby give permission to OASD's trained staff to give the medication(s) to my child according to the directions stated above and further authorize them to contact the child's physician. I agree to hold the Oconomowoc 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 this medication at school.
- I agree to notify the school in writing at the termination of this request or when any changes in the above order are necessary.
- I give permission for the school staff, including the district designated health care professional, to contact my child's physician with any concerns regarding medication administration.
- I give the school staff, including the district designated health care professional, permission to call me with any concerns regarding medication administration.

⇨ **Should this medication be sent with a District Employee for your child on field trips?** ☐ **Yes** ☐ **No**

⇨ **The last week of school, how should medications be returned? Note: controlled substances will need to be picked up by a parent/guardian only.** ☐ **Sent home w/Student** ☐ **Parent/Guardian Pick-Up**

____ **Date** ___________________________
(Print) Parent/Guardian Name

____
(Signature) Parent/Guardian Name

By signing this form, I allow the above named physician/ (office) to send by electronic transmission this form to the Oconomowoc Area School District for the purpose of continuing health care at school.

Prescription medications REQUIRE physician signature.

Physician Signature:	**Date:**
Physician Name (please print):	

By signing this form, I, the physician, am stating I have reviewed and agree with the plan to administer the named medications to the student specified on this form.

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Medications:

All medication must be supplied by the parent/guardian. The school will not supply any type of medication.

Over the counter medications need to be supplied in the original manufacturer's package and must list the ingredients and recommended therapeutic dose. Prescription medications must be supplied in a pharmacy-labeled package/bottle and it must specify the student's name, prescriber's name, name of the medication, dose, the effective date, and the directions for use. Expired medications cannot be dispensed.

Medications will be kept in the health room for safe storage and administration. Emergency medications, such as Epi-Pens, Glucagon, Inhalers, or Diastat may be carried by the student **only** if the physician deems it is safe for the student to self-administer (the physician will indicate this on the specific health care plan).