School District of Manawa
"Students Choosing to Excel, Realizing Their Strengths"
800 Beech Street | Manawa, WI 54949 | (920) 596-2525
District Fax (920) 596-5308 | Elementary Fax (920) 596-5339 | Jr./Sr. High Fax (920) 596-2655

ADMINISTRATION OF MEDICATION CONSENT

School Year _____

Student's Name: _____ Birth Date ___/___/___ Age _____ Grade _____

School Attending:
☐ Elementary School • Phone (920) 596-5700 • Fax (920) 596-5339 Teacher/Advisor _____
☐ Little Wolf Middle/High School • Phone (920) 596-5800 • Fax (920) 596-2655 Teacher/Advisor _____

MEDICATION One Medication Per Form

Name _____ ☐ Prescription ☐ Over the Counter Time _____ or ☐ As Needed

Dosage _____ Route _____ Start Date _____ End Date _____

Reason for Medication _____

Negative Side Effects _____

PARENT • GUARDIAN • EMERGENCY CONTACT

Parent / Guardian 1
Name _____ Relationship _____ Phone ( ) -
Workplace _____ Work Phone ( ) -

Parent / Guardian 2
Name _____ Relationship _____ Phone ( ) -
Workplace _____ Work Phone ( ) -

Emergency Contact 3
Name _____ Relationship _____ Phone ( ) -
Workplace _____ Work Phone ( ) -

CONSENT FOR MANAGEMENT OF HEALTH CONDITION AT SCHOOL OR SCHOOL-SPONSORED ACTIVITIES

I, the parent/guardian of the above-named student, grant permission for designated school staff to administer this medication. Furthermore, I agree to:

1. Provide the necessary supplies and equipment. Provide medication in the original pharmacy labelled container or manufacturers unopened container, within expiration date.
2. Notify school staff or school district nurse and complete new forms for changes in the student's health status, medical orders and any change in the student's health care provider.
3. Ensure this form is signed by the practitioner who manages the medical condition. Physician signature is required for prescriptions or over-the-counter (OTC) medication doses that exceed the manufacturers recommended dosage listed on the packaging.
4. Authorize the school nurse and/or designated staff to communicate directly with my child's primary care provider or specialist regarding my child's health condition and medication.
5. Authorize school staff who are interacting directly with my child to be informed about health conditions and medications.
6. Submit new forms annually if the health condition and/or need for medication still exists or inform the school that the condition no longer exists and provide documentation of such, if deemed necessary.
7. Hold without liability the School District of Manawa, its' Board of Education, administration, and all employees and agents who are acting within the scope of their duties in all claims arising from the administration of this medication and treatment of this health condition, to policy at school.

Parent/Legal Guardian Signature _____ Date _____

Student signature is required if student is 18 years old or attaining 18 years old during the school year

Student Signature _____

Date _____

PHYSICIAN INFORMATION SIGNATURE REQUIRED FOR ALL PRESCRIPTIONS AND OTC'S EXCEEDING MANUFACTURER RECOMMENATIONS

Print Name _____ Phone ( ) -
Medical Facility _____ Fax ( ) -
Address _____ Physician Signature _____
City, State, Zip _____ Date _____

MEDICATION ADMINISTRATION LOG

School Year_____

Student Name: _____ DOB:_____ Grade/Teacher_____

Medication: _____ Dosage: _____ When:_____

Person Administrating:_____ Initials: _____

Person Administrating:_____ Initials: _____

Person Administering: Enter time & your initials or A = Absent R = Refused FT = Field Trip X = No School

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