School District of Manawa

Student Health Services
District Nurse Olivia Koehn RN, BSN|(920) 596-5841
Health Aide MES Kris Thompson|(920) 596-5735
Health Aide LWJSHS Sandy Dunnihoo|(920) 596-5845
Elementary Fax (920) 596-5339 | Jr./Sr. High Fax (920) 596-2655

Medication Administration Consent Form 2017/2018

Student Name _____ Date of Birth _____

School _____ Teacher _____

Student ID # _____ Grade _____

This form only needs to be filled out for medications that will be taken at school. A separate form will be needed for each medication to be taken at school.

If the medication is a prescription, then the prescribing provider should sign in the physician information box below and the medication will need to be supplied by the parent/guardian in original container with prescription label affixed. Parent signature is also required.

If the medication is over-the-counter it must be provided by parent/guardian in original container and will be given per manufacturer instructions; a physician's signature is not required. Parent signature is required.

☐ **Prescription Medication** ☐ **Over-The-Counter Medication**

Medication Name	Dose (amount)	Frequency/ Timing-daily or as needed	Route (ex. Oral)	Diagnosis/ Reason for medication	Special Instructions/Conditions under which to give as needed medications.

Please list possible unfavorable reactions and interventions staff should perform: _____

Parent consent for medication administration while at school or other school related activities

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

1. Provide the necessary supplies.
2. Notify the school staff and complete new consent for changes in orders from the student's health care provider.
3. Authorize the school nurse to communicate with my child's primary care physician or specialist regarding my child's medication as needed.
4. School staff interacting directly with my child may be informed about this medication.
5. 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 to policy at school.

Parent/Guardian Signature_____ Date_____

Student Signature (if the student is 18 years old or will turn 18 during the 2017/2018 school year)

_____ Date_____

Physician Information

Print Name of Provider_____ Institution Name _____

Phone Number_____ Fax Number _____

Address _____

Signature of Provider_____ Date_____

Medication Administration Log on back of form.

Medication Administration Log

Student's Name: _____ **Date of Birth:** _____ **Grade:** _____
Medication Name: _____ **Dose/Route:** _____ **Time to be given:** _____
Start date: _____ **Stop date:** _____

Key: Initial=medication administered A=student absent R=refused X=no school FT=field trip E=medication error

	September	October	November	December	January	February	March	April	May	June	July	August
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20												
21												
22												
23												
24												
25												
26												
27												
28												
29												
30												
31												

Delegating school nurse: Olivia Koehn, RN BSN **Initials:** OK **Phone number:** (920)596-5841 or 920-505-0320
School personnel authorized to administer the medication: 1. _____ **Initials:** _____
2. _____ **Initials:** _____
3. _____ **Initials:** _____