

School RN Signature _____

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 for School Year:

*Parents please remember that only one medication may be placed on each medication consent form.

Student Name				Date of Birth				
School Building		Т	eacher	Gra	nde			
Parent/Guardian Name a	nd Phone Num	ıber(s)						
Parent/Guardian Name a	nd Phone Num	nber(s)						
Emergency Contact Name	e and Phone Nu	umber(s)						
	Institution Name and Phone Number(s)							
Medication Start/Stop Date Special Instructions/Conditions to give (if as needed)								
Medication Name		Timing-daily		Diagnosis/ Reason for medication	Negative side effects			
1. Provide the necessary s 2. Notify the school staff o 3. Notify the school staff a 4. Ensure this form is sign 5. Authorize the school nu medication. 6. School staff interacting 7. Submit new forms annu documentation of such is 8. Hold without liability the scope of their duties in a	e-named student, grupplies and equipment of school district number of the appropriates to communicate directly with my chally if the health coif deemed necessaries School District of all claims arising fitture	grant permission forment, including meaurse of any changes forms as necessary iate medical provide te directly with my hild may be informondition/need for a ry. of Manawa, its Boar rom the administrations and the administrations old or will turn for a result of the second to the administrations of the administration of the admin	or designated school dication in the ore in the student's for changes in ore ler (provider who exhibits a primary of each of the child's primary of ed about health of medication still end of Education, action of this medication of the medication	pool staff to administer this medicing in al, pharmacy labelled contain the alth status. It is a manages the medical condition care provider or specialist regard conditions and medications. It is a manage to inform the school that the diministration, and all employees cation and treatment of this heal Date Date Date	cation. Furthermore, I agree to: iner within expiration date. are provider. a). ding my child's health condition and he condition no longer exists and provide as and agents who are acting within the lth condition, to policy at school.			
Print Name of Provider	-	_						
Phone Number			Fax N	umber				
Address	Special Instructions/Conditions to give (if as needed) Special Instructions/Condition Instructions/Conditions and give in the student of the above-named student, grant permission for designated school staff to administer this medication of the above-named student, grant permission for designated school staff to administration of the above-named student, grant permission for designated school staff to administration of the student's health care provider. Special Instructions is signed by the appropriate medical provider (provider who manages the medical condition). The student is the appropriate medical provider (provider who manages the medical condition). The student is the special provider (provider who manages the medical condition). The student is the special provider (provider who manages the medical condition). The student is the special provider (provider who manages the medical condition). The student is the special provider (provider who manages the medical condition). The student is special provider (provider who manages the medical condition). The student is special provider (provider who manages the medical condition). The student is special provider (provider who manages the medical condition). The student is special provider (provider who manages the medical conditio							
Signature of Provider				Date				

Date____

MEDICATION ADMINISTRATION LOG

Student's Name: _			Date of Birth:Dose:				Me	edication Start/St	op Date:			
Medication Name:			Dose:			Route:			_Time to be	given:		
Key: Initials and time=given as order		as ordered A	A=student absen	t R=student refused		X-no school during admin time		FT=field trip	E=error	NA-none available		
September	October	November	December	January	February	March	April	May	June	July	Augu	
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Delegating school	nurce.			Initials:	Dhona	Number: (920) 5	596_5841					
Delegating school School personnel	authorized to	administer the 1	— medication:	1	1 Hone	11umoci. (320).	Initials:					
sensor personner	asinonized to	administer the l	modication.	2.			Initials:					
				Z								