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 _____ Teacher _____Grade _____

Parent/Guardian Name and Phone Number(s)_____

Parent/Guardian Name and Phone Number(s) _____

Emergency Contact Name and Phone Number(s) _____

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

Medication Start/Stop Date _____ Special Instructions/Conditions to give (if as needed)_____

Medication Name	Dose (amount)	Frequency/ Timing-daily or as needed	Route (ex. Oral)	Diagnosis/ Reason for medication	Negative side effects

Parent consent for management of health condition while at school or other 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, including medication in the original, pharmacy labelled container within expiration date.
2. Notify the school staff or school district nurse of any changes in the student's health status.
3. Notify the school staff and complete new forms as necessary for changes in orders from the student's health care provider.
4. Ensure this form is signed by the appropriate medical provider (provider who manages the medical condition).
5. Authorize the school nurse to communicate directly with my child's primary care provider or specialist regarding my child's health condition and medication.
6. School staff interacting directly with my child may be informed about health conditions and medications.
7. Submit new forms annually if the health condition/need for medication still exists or inform the school that the condition no longer exists and provide documentation of such if deemed necessary.
8. 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/Guardian Signature_____ Date_____

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

_____ Date_____

Physician Information

Print Name of Provider_____ Institution Name _____

Phone Number_____ Fax Number _____

Address _____

Signature of Provider_____ Date_____

School RN Signature _____ Date_____

MEDICATION ADMINISTRATION LOG

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

Key: Initials and time=given as ordered A=student absent R=student refused X-no school during admin time FT=field trip E=error NA-none available

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Delegating school nurse: _____ Initials: ___ Phone Number: (920) 596-5841
School personnel authorized to administer the medication:
1. _____ Initials: _____
2. _____ Initials: _____
3. _____ Initials: _____