

# BOWLER SCHOOL DISTRICT

500 S Almon Rd  
Bowler, WI 54416  
Phone (715) 793-4101

Elementary & High School Fax

(715) 793-1302

## PARENT / GUARDIAN CONSENT FORM FOR MEDICATION

Student's Name	Birthdate	Grade
Parent's Name	Phone where parent can be reached during school day	

If <b>INHALER</b> , may carry & self-administer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If <b>INSULIN</b> , may carry & self-administer	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Medication / dosage

Reason for medication

Name of physician or medical provider ordering this medication; include location of clinic or phone

Time it is to be given	How it is to be given:
------------------------	------------------------

If medication is given only as needed, what are the conditions under which school personnel should give it?

I hereby give my permission to the school staff or nurse to give the medication to my child according to the written instructions above and of the medical provider as shown on the Physician Order section below. I also hereby give my permission to the school staff or nurse to contact the provider if necessary. I agree to hold the Bowler School District and its employees and agents harmless in any or all claims arising from the administration of this medication at school. I agree to notify the school at the termination of this request or when any change in the above orders is necessary.

Signature of Parent/Legal Guardian

Date

## PHYSICIAN ORDER FOR MEDICATION ADMINISTRATION

Student's Name	Birthdate
----------------	-----------

Diagnosis / Reason for Medication

If <b>INHALER</b> , may carry & self-administer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If <b>INSULIN</b> , may carry & self-administer	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Medication	Route	Dose	Time of administration at school	Duration (Not to exceed current school year)	Special Instructions Reasons for school staff to contact provider
				From: To:	
				From: To:	

Physician / Provider Name

Clinic / Location

Phone

Physician / Provider Signature

Date

I acknowledge by my signature that I will assist and advise designated school personnel with regard to the medication administration described above, which includes accepting direct communication. I further understand that if the student is allowed to self-administer medication that proper instruction has been given.