MANITOWOC PUBLIC SCHOOL DISTRICT
Manitowoc, Wisconsin

Consent to Administer Medication to be Given at School

Student_____ D.O.B._____ School_____ Grade_____

Parent_____ Home #_____ Work/Cell/Pager #_____

Prescribing Physician_____ Physician's Office Phone Number_____

Dear Parent/Guardian:
The Manitowoc Public School District is **required** to have written parental/guardian consent for all medication given in the school. Additionally, prescription medication requires physician directions and signature.

PARENT:
I request that my child be assisted by designated school personnel in taking the following medication.

_____

Name of Drug Dosage Time Route

as authorized by me (and my physician if prescription). Specific questions/concerns may be communicated to the physician by a professional staff member serving the school.

I further agree to hold the Manitowoc Public School District and all employees harmless in any and all claims arising from the administration of this medication at school.

I agree to notify the school in writing at the termination of this request or of any change in medication.

*It is highly recommended that medication be transported to school by the parent. According to school policy, all prescription medications must be in a properly labeled pharmacy bottle and over the counter medications must be in their original containers.

_____ _____

Signature of Parent/Guardian Date

NOTE: Any change in medication will require a new form. For year-long medications, consent to administer will expire at the end of each school year.

PHYSICIAN: (for prescription drugs only)
The following is to be completed by the child's physician prior to administration at school. Please indicate:

1. Is the medication a PRN drug? _____YES _____NO

2. Under what conditions or schedule the drug should be given and repeated_____
   _____
   _____

3. Side effects (expected or predicted)_____
   _____
   _____

4. Purpose of the medication _____

Medication	Route PO: G-tube; IM; Rectal, Inhalation	Amount to be Taken	Time to be Given	Duration of Medication

_____ _____

Signature of Physician Date

Questions or concerns regarding this medication's effects may be directed to the physician at any time.