Port Edwards Public Schools
801 Second Street
Port Edwards, WI 54469
Phone: 715-887-9000
www.pesd.k12.wi.us

Prescription Medication Consent/Order Form

To be completed by parent/guardian:

Name of Student_____ Date of Birth:_____Grade_____

I give permission for my son/daughter to receive medication during school hours and during school sponsored activities/field trips that occur after hours. I will be responsible for:

1. Delivery of medication: Prescription medication must come to school in the original manufacturer's packaging and be labeled with the student's name. Medication must be delivered by parent/guardian.
2. Maintaining a sufficient supply of medication. Empty bottles will be disposed of by school staff unless informed otherwise.
3. Keeping school personnel informed of changes in the medication (dosage,time)
4. Understanding that the above information may be shared with necessary school personnel. The above order shall remain in effect through the end of the current school year unless discontinued/changed by me in writing.

I hereby release the board of Education and its agents and employees from any and all liability that may result from my child taking this medication. I understand that this medication may be administered by non-medically trained personnel. I understand that this medication consent is good for the entirety of the school year (and summer school if needed) unless I notify health office staff. My signature below indicates that I have fully read and understand the above information.

At the end of the school year please:

- ☐ **Contact me to pick up remaining medication**
- ☐ **Dispose of remaining medication**
- ☐ **Send medication home with my student**

Parent/Guardian Signature: _____ Date: _____

To be completed by Provider:

Provider Order

Name of Medication	Dosage	Form	Time	Possible Side Effects	Reason for Medication

For Metered Dose inhalers and Epi-pens only:
The patient has received instruction, has demonstrated competency and may self-carry & administer
YES/NO

The agree with the following statements regarding the medication ordered above:

- The medication is to be administered in accordance with the written instructions/agreements
- I agree to accept communication about the student/medication
- I understand non-medically trained school personnel may give this medication
- My signature indicates that I have fully read and understand the above information

Provider Signature:_____ **Date:** _____

Provider Name: _____ **Phone Number:** _____