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 the following 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 pharmacy packaging. Medication should 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.

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

I hereby release the board of Education and its 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) 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 (check one):

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

Provider Name: _____ Provider Phone Number: _____
Parent/Guardian Signature: _____ Date: _____

TO BE COMPLETED BY THE PROVIDER: The medication listed is to be administered in accordance with written instructions noted. I agree to accept communication about this student and/or medication. I understand non-medically trained school personnel may give this medication. Please contact me if:

_____

Provider Signature:_____ Date: _____

Provider Name: _____ Phone Number: _____

Reviewed 5/2024