

FOND DU LAC SCHOOL DISTRICT
Physician's Order for Administration of Medication

This order for medication is required to be completed and presented to the school a child attends before any prescription drug may be administered to the child. (Wisconsin Statutes 118.29 (2)(a)(2).)

Student's Name _____ D.O.B. _____ Gender ___(M)___(F) School _____ Grade _____
 Parent's Name _____ Address _____ Phone _____
 Physician's Name _____ Physician's Address _____ Phone _____
 Diagnosis _____

NO MEDICINE WILL BE GIVEN UNLESS IT IS IN THE ORIGINAL CONTAINER

- Physician please note: For the safety of our students, standard medication times are 8:30 am and lunch hour. Only when absolutely necessary indicate times outside of these standardized times for medication to be given.

Medication	Dose	Time to be Given			Duration (list dates)		Physician: Please list conditions or adverse reactions indicating parental and/or physician notification.	PRN (as needed medication) Indicate conditions under which medication should be given.
		8:30 AM	Lunch Hour	Other (list time)	Start	Finish		

(School staff will not be required to administer any medication by means other than ingestion.)

C-4

INHALERS:

Students in grades 6-12 are permitted by law to possess and use inhalers independently with physician's signature. K-5 students may use inhalers independently at the discretion of physician and parent.

Level of independence recommended for this student:

- _____ Totally independent (Has been trained by physician on use and is prepared to self-administer)
- _____ Inhaler is kept by designated school personnel and used under supervision.
- _____ Other _____

Physician's Signature _____ Date _____

PARENT/GUARDIAN CONSENT FORM

I hereby give permission to the persons designated below to give medication(s) to my child according to the directions stated above and further authorize them to contact the child's physician. I agree to hold the Fond du Lac School District, its employees and agents who are acting within the scope of their duties harmless (Wisconsin Statutes 118.29 (2)(a)(1)(2)(3)(b).)

I agree to notify the school in writing when any change in the above order is made.

Signature of Parent/Guardian _____ Date _____

Name of designated person(s) administering medication (to be completed by school principal and/or School Health Program Personnel).

1. _____ 2. _____ 3. _____

