The Arrowhead Union High School District

South Campus/District Office
700 North Avenue
Hartland, Wisconsin 53029
(262) 369-3611 x4108 Health Room

North Campus
800 North Ave.
Hartland, Wisconsin 53029
(262) 369-3612 x4208 Health Room

http://www.ahs.k12.wi.us

PRESCRIPTION MEDICATION CONSENT FORM

Name of Student _____ **Grade** _____

When it is a necessity that a student receives prescription medication at school:

1. Written authorization for medications expire at the end of the school year if not discontinued during the course of the year. New orders need to be obtained at the beginning of each school year.
2. Written consent from parent/legal guardian/18 year old student must be received before any medication is administered.
3. Written doctor's orders must be received stating:
    a. Name of medication
    b. Dosage
    c. Time to be administered
4. The school nurse may obtain telephone orders from the prescribing physician for administration of medication until written orders are received.
5. The medication must be in a pharmacy labeled container with the student's name, dosage and time to be given on it.
6. Students are not permitted to keep prescriptive medication, except asthma inhalers, insulin or an epi-pen as prescribed by their physician, under their control in such places as their backpack, purse or pockets
7. The prescriptive medication shall be kept under lock and key at all times in the Health Room.
8. I hereby give my permission for the school nurse, health room personnel, office staff or authorized school personnel to give the medication to my child according to the directions stated below.
9. I give my permission to the school nurse to contact the student's physician.
10. I further agree to hold the Arrowhead School District, and the above-identified person(s) harmless in any or all claims arising from the administration of this medication or the performance of this procedure at school.
11. I agree to notify the health room at the termination of this request or when any change in the above orders is necessary.

_____ _____

Signature of parent/legal guardian/18 year old student *Date*

Physician Medication Orders

Name Of Medication	Dosage	Time to be administered OR PRN for_____	Duration – All school year Or_____

May the student self-administer asthma/inhalers, diabetes/insulin, or allergies/epi-pen,? YES___NO___

For asthmas inhalers, epi-pens and insulin please fill out individualized health plan instead.

*****Physician Signature***_____

Date_____ ***Phone***_____