Arrowhead Union High School District
700 North Avenue
Hartland, WI 53029
Phone: 262-369-3611 x4108
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Prescription Medication Consent Form

Student Name:	Graduation Year:

Parent/ Guardian Medication Consent

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

1) Written authorization for the medication will expire at the end of the school year, if not discontinued during the course of the year. New orders need to be obtained prior to 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. Student's name
   b. Name of the medication
   c. Dosage
   d. Time to be administered.
4) The medication must be in a pharmacy labeled container with the student's name, dosage, and time to be given on it.
5) Students are NOT permitted to keep prescription medication, except asthma inhalers, insulin, or epi-pens as prescribed by their physician, under their control in such places as backpacks, purses or pockets.
6) The prescription medication shall be kept under lock and key at all times in the health room.
7) I, hereby, give my permission for the school nurse, health room personnel, office staff or authorized school personnel to give the medication to my student according to the directions below.
8) I, hereby, give the school nurse permission to contact the student's physician.
9) 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.
10) I agree to notify the health room at the termination of this request or when any change in the above orders is necessary.
11) Parents/guardians must pick up any unused mediation by the last day of school, or the last day of attendance if student leaves mid-year. Any medication not picked up will be destroyed. NO medication will be stored over the summer.

Parent/ Guardian Signature:	Date:

Physician Medication Order		
Name of Medication:	Reason for Use:	Dosage and Frequency:
	Time to be Given:	Route:
Physician Authorization		
Physician's Name:	Physician Signature:	Date:

Health Office Personnel - Verify the Following:

1) **Prescription medication form is properly filled out and accompanies the medication. The form must be signed by both the physician and parent and the form matches the information on the medication bottle.**
2) **The medication is in its original packaging with pharmacy label, and is not expired.**

FOR OFFICE USE ONLY:

DATE	AMOUNT OF MEDICATION DELIVERED/RETURNED	STAFF SIGNATURE	PARENT/GUARDIAN SIGNATURE OR SECOND VERIFIER	SKYWARD UPDATED