

School District of Whitewater
Administering Medication to Students
(Please return to your child's school)

Student Name _____
Birthdate _____ Male _____ Female _____
School _____ Grade _____
Parent/Guardian _____
Home Phone _____ Work Phone _____

Physician's Name _____
Physician's Address _____
Physician's Phone _____
Physician's Fax _____

To Parent/Guardian/Physician:

The School District of Whitewater is required by state statute to give prescription medication to students only with the complete directions from a physician and signed consent by parent/guardian. Medication must be supplied in the original container or packaging. For safety and liability reasons, medication received in any container other than the original will not be acceptable for staff administration. By signing this form, you release the Board of Education, its agents and employees from any and all liability which may result from taking this medication.

Medication _____ Dosage _____ Frequency _____
Start Date _____ End Date _____

Form: _____ Tablet/Capsule _____ Liquid _____ Inhaler _____ Nebulizer _____ Injection
_____ For episodic/emergency events only _____ Other _____

*Emergency Medications (inhaler, glucagon, insulin, epi-pen). Student to self-administer/carry: yes _____ No _____

Time(s) to be given _____ Reason for this medication _____

If given on an "as needed" basis, please describe _____

Special instructions _____

Side effects (expected or predictable) _____

I, the prescribing physician, am willing to accept direct communication from the person dispensing and administering the above medication.

Physician's Signature _____ Date _____
(Signature required for all prescription medication)

Parent/Guardian Signature _____ Date _____
(Signature required for all prescription and nonprescription medication).