Wausau School District

Medication Administration Consent

Student Name: ____ **DOB**___________
Parent/Guardian: ____
Phone: Home:__________________ **Work**:__________________ **Cell**:___________________

Individual Action Plans will be used for medication orders for the following conditions:
Asthma Severe Allergies Diabetes Seizures

Medication Name:
____

Administration Instructions:
____

Effective Date: ___________ to ___________

Medication Name:
____

Administration Instructions:
____

Effective Date: ___________ to ___________

Medication Name:
____

Administration Instructions:
____

Effective Date: ___________ to ____________

For students self- carrying* ***rescue* *medication, it is recommended that an additional (back-up) medication be available in the health office.*

Comments:
____
____

Health Care Provider Name (print)**:** ____

Health Care Provider Signature: _________________________________ **Date:** __________
Practitioner signature- Directs the above medication administration and indicates a willingness to communicate with staff who administers the medication.

Parent Signature: ____ **Date:** __________
Parent signature- Allows staff to give the above medication and to contact the health care provider if necessary.