Wausau School District

Medication Administration Consent Form

Student Name: ____**DOB**:__________________
Parent/Guardian: ____
Home Phone: _________________________**Work**:____________________**Cell**:__________________
Health Care Provider: ____**Phone:**________________

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

Practitioner signature -Directs the above medication administration and indicates a willingness to communicate with staff who administers the medication.
Parent signature -Allows staff to give the above medication and to contact the health care provider if necessary.

Comments: ____
____

Health Care Provider Signature: ______________________________________ Date: ___________

Parent Signature: ____ Date:____________