

MEDICATION/TREATMENT REQUEST
School District of New Holstein

453.4 Exhibit 1

Please check: Medication Treatment

All portions of this Medication/Treatment Request form must be completed before medication can be administered by school personnel. Incomplete forms may result in the form being returned for full completion.

Student _____ School _____

Child's Date of Birth _____ Grade _____ Teacher _____

Name of Medication _____ Dose: _____

Method: (*please circle*) Oral Inhaled Injected Neb Topical Eye Ear Other _____

To be given: Daily at the following times: _____

As needed for: _____ How often: _____

Dates to be given: From _____ to _____

Additional Information _____

Healthcare Provider's Name _____ Healthcare Provider's Phone # _____
(please print)

The school personnel have my permission to administer this medication/treatment as indicated above. I agree to hold the School District of New Holstein, its employees or agents who are acting on this request, harmless in any and all claims arising from the administration of this medication/treatment at school. I also agree to inform the school immediately and in writing of any change or discontinuation of this order. I shall pick up unused portions of the medication/treatment within 3 business days of completion of the school year or when this order has been discontinued. I acknowledge that the medication/treatment supplies will be destroyed if it has not been picked up after a 10-day period following notification.

***ASTHMA INHALERS:** This student is capable of self-administration and may carry inhaler.* Circle: YES or NO

***EPI PENS ONLY:** This student may self-carry epi-pen.* Circle: YES or NO

Parent/Guardian Signature _____ Date _____

HEALTHCARE PROVIDER AUTHORIZATION

The healthcare provider whose signature follows hereby authorizes school personnel to administer medication/treatment as prescribed and also agrees to accept communication regarding the administration procedures. It is understood that the medication/treatment will be given by non-licensed, but specially trained personnel, and *the reason(s) that the medication/treatment must be given during the school day should be given.* Temporary orders (except controlled substances) from healthcare providers written on prescription pads or faxed will be accepted for a period of seven days from the date of the order. Prescription inhalers may be carried by the student per section 118.291 (Wis. Stats.) with written signature from healthcare provider and parent/guardian.

***ASTHMA INHALERS:** This student is capable of self-administration and may carry inhaler.* Circle: YES or NO

***EPI PENS ONLY:** This student may self-carry epi-pen.* Circle: YES or NO

_____ Phone # _____ Date _____

Healthcare Provider's Signature