

SCHOOL MEDICATION/PROCEDURE FORM
NORTH CRAWFORD SCHOOL DISTRICT
FAX 608-624-6269

STUDENT'S NAME	BIRTH DATE	GRADE	TEACHER
MEDICATION/PROCEDURE	DOSAGE		TIME/FREQUENCY
SCHOOL YEAR OR EFFECTIVE DATES		STUDENT'S PHYSICIAN	
REASON FOR MEDICATION/PROCEDURE			

NOTE: FOR PRESCRIPTION MEDICATION: SIGNED PARENT CONSENT AND SIGNED PHYSICIAN'S ORDER REQUIRED. FOR NON-PRESCRIPTION MEDICATION: SIGNED PARENT CONSENT REQUIRED.

<u>PARENT CONSENT</u> : COMPLETE FOR EACH MEDICATION/PROCEDURE AT SCHOOL		
<p>I request that this medication/procedure be administered at school. Medication will be supplied in it's original, properly labeled container. This order is in effect for this school year unless otherwise indicated. I will notify the school in writing for any changes and obtain a new physicians order. I authorize school personnel to contact my child's physician if needed. I release the school district from any liability claims as a result of the administration of this medication or procedure as directed.</p>		
DATE	TELEPHONE NO.	PARENT/GUARDIAN SIGNATURE

<u>PHYSICIAN ORDER</u> : COMPLETE FOR EACH PRESCRIPTION MEDICATION/PROCEDURE AT SCHOOL		
<p>The above medication/procedure is to administered during the school day in accordance with the above instructions. Please contact me if the following symptoms occur: _____</p>		
Additional information: _____		
For Asthma inhalers ONLY - Student may carry inhaler and in school YES/NO		
DATE	TELEPHONE NO.	PHYSICIAN'S SIGNATURE