Lodi Primary School
(PreK/K/OSC)
103 Pleasant Street
Lodi, WI 53555
Phone: (608) 592-3855
Fax: (608) 592-1015

Lodi Elementary School (1-5)
101 School Street
Lodi, WI 53555
Phone: (608) 592-3842
Fax: (608) 592-1025

Lodi Area Middle School (6-8)
900 Sauk Street
Lodi, WI 53555
Phone: (608) 592-3854
Fax: (608) 592-1035

Lodi High School (9-12)
1100 Sauk Street
Lodi, WI 53555
Phone: (608) 592-3853
Fax: (608) 592-1045

MEDICATION REQUEST/CONSENT FORM

Medications are to be administered at home whenever possible. If it is necessary for a student to receive medications at school, all appropriate portions of this form MUST be completed before medication can be given at school. One form for EACH medication is required.

Student Name:_____School:_____Grade:_____

(All medication must be in original over-the-counter or prescription container.)

Type of Medication:		Date Start:		Date End:	
Dosage:		Frequency:			
Possible Side Effects:					
If PRN, describe conditions under which to administer:					

❑ Permission is given to the school to administer early A.M. dose of medication, if forgotten at home (per parent/guardian request).

ASTHMA INHALERS AND EPI PENS ONLY:

[] Yes [] No This student and his/her parents/guardians have been instructed in self-administration and student may carry inhaler or EPI pen and self-administer in school.

PARENT/GUARDIAN CONSENT: (Complete for all prescription and non-prescription medication/procedures at school.)

< I request and authorize that this medication be administered at school, by school personnel.
< I will supply medication in its original, updated, properly labeled container.
< This order is in effect for this school year unless otherwise indicated.
< I will obtain a new physician's order and notify the school in writing for any changes.
< I authorize school personnel to exchange information verbally or in writing with my child's physician regarding this medication or the conditions for which it is prescribed.
< I understand that when medication at school is no longer needed, an adult will pick up remaining medication. *It will not be sent home with the child.*
< I understand that all medication should be delivered to the school by parent/guardian.
< I understand that medication will be given by non-medically trained school personnel.
< I understand medication will only be given if prescribed within normal therapeutic ranges based on the physicians' desk reference.
< I agree to hold the School District, its employees and agents who are acting within the scope of their duties, harmless in any and all claims arising from the administration of this medication at school.

..... REQUIRED SIGNATURES .....

The above medication is to be administered during the school day in accordance with the above instructions and agreements. I agree to accept communication about student/medication and understand the medication will be given by non-medically trained school personnel.

[] Yes [] No I give permission to have my child's photo displayed on this form.

N **Parent/Guardian Signature:_____** **Date:___/___/___**

N **Physician/Practitioner Signature:_____** **Date:___/___/___**

Physician Name:_____Address:_____Phone:_____

Date Received at School: _____/_____/_____ Received by:_____