SCHOOL DISTRICT OF LODI

District Office	High School	Middle School	Elementary School	Primary School
115 School Street	1100 Sauk Street	900 Sauk Street	101 School Street	1307 Sauk Street
608-592-3851	608-592-3853	608-592-3854	608-592-3842	608-592-3855
Fax: 608-592-3852	Fax: 608-592-1045	Fax: 608-592-1035	Fax: 608-592-2507	Fax: 608-592-1015

PRESCRIPTION MEDICATION FORM

For a student to receive a medication at school, all appropriate portions of this form **MUST** be completed. **For prescription medication BOTH a health care provider and parent signature are required.**

Student Name:____________________________________**School:**__________________**Grade:**_____

Date of Birth:__________________________ **Age:**___________________

<u>Section to be completed by Health Care Provider:</u>

Medication Name:	Route	Dose	Frequency/ Time	Start date	End date	Possible Side effects:

<u>ASTHMA INHALERS AND EPINEPHRINE AUTO INJECTORS ONLY:</u>

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

<u>REQUIRED HEALTH CARE PROVIDER SIGNATURE</u>

The above medication/procedure 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.

Physician/Practitioner Signature: _______________________________ **Date:** ___/___/___

Physician Name____________________________Address:__________________________Phone:__________

Please see other side FOR PARENT/GUARDIAN CONSENT

PARENT/GUARDIAN CONSENT:

We have some stock medications in the nurse's office. If you want your student to be able to use these medications at school, please check yes.

[] Yes [] No Hydrocortisone Cream 1% - for rash
[] Yes [] No Triple Antibiotic Cream- for minor scrapes and cuts.
[] Yes [] No Cough drop: containing menthol- for sore throat or cough

REQUIRED PARENT/GUARDIAN SIGNATURE

I have read the parent responsibilities and understand my part in providing my child this medication at school. The above medication is to be administered during the school day in accordance with the above instructions and agreements. I authorize the school personnel to consult with the physician/licensed prescriber named on the medication consent in regard to any questions about the listed medication or medical condition being treated by the medication. I agree to accept communication about student/medication and understand the medication will be given by non-medically trained school personnel**. Prescription medications are NOT permitted to be self-administered by a student except inhalers and epinephrine auto injectors which are allowed by state law.**

Parent/Guardian Signature:___________________________________ Date:___/___/___

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