Wolf River Lutheran High School
W7467 River Bend Road, Shawano, WI 54166
(715) 745-2400 – office@woflriverlhs.org – www.wrlhs.org

Prescription Medication Consent Form

Child's Name _____ *DOB* _____

This is to certify that in order to keep this child in optimum health and/or help maintain optimum performance at school, it is necessary that medication be given during school hours.

1. *Name of Medication* _____
2. *Reason for Medication* _____
3. *This medication is to be given in the form which is circled:*
   tablet *ointment* *capsule* *inhalation* *liquid* *injectable*

Re: Asthma Inhalers (WI Statue 118.291 allows students with asthma to possess and use metered dose and dry powder inhalers with written permission from their physician)

_____I have instructed this student in the proper use of inhaled asthma medications. It is my professional opinion that his student should be allowed to carry and use this inhaler by self.

4. If this medication is on a PRN (as needed) schedule, please describe how the person supervising medication is to determine when the medication is needed: _____
   _____
5. Dosage (amount to be administered during school hours) _____
6. At what times during school hours should it be administered? _____
7. Side effects (expected or predictable): _____
8. The student's parents/guardian knows of this request and is in full agreement that this medication will be administered as indicated. Should the student manifest any of the following symptoms, please discontinue administration and notify the parents and/or my office immediately. Contraindications for the administration of medication are: _____
9. Further written instructions will follow from me to the school if they drug is to be discontinued or the dosage/administration time is changed from these instructions.

In accordance with the 1983 Wisconsin Act 334, I agree to retain the power to direct, supervise, decide, inspect and oversee the administration of such medications(s). Direct contact shall be made with me at any time should you have any questions.

Physician Name: _____ Phone: _____

Physician's Signature: _____ Date: _____

*Before prescription medication may be administered by school personnel, this form must be completed by a licensed physician.