MOUNT HOREB AREA DISTRICT
CONSENT AND INSTRUCTION
FOR ADMINISTERING MEDICATION AT SCHOOL

Student's Name_____ Date of Birth_____ Grade _____

Name of Medication _____Expiration date on medication_____

Dosage and Hour to be given _____Start date _____Stop date_____

Reason for Medication _____

Medical Provider's Name (If Prescription) _____ Phone _____

I hereby give my consent to the designated school personnel to administer the above referenced medication to my child according to the written instructions contained herein and, in the case of a prescription drug, to contact by phone or fax my child's medical provider for signature or to confirm order. I further agree to hold the Mount Horeb Area School District, its officers, 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 to my child.

I further agree to notify the school in writing at the termination of this request or when any change in the above orders is necessary.

Date _____ Parent/Guardian Signature _____

If a prescription medication is involved, contact should be made with me should the student receiving the medication develop any of the following conditions or reactions to the medication (if none, so state). _____

If this prescription is for an inhaler or Epi-pen, has the student been instructed and authorized to carry and self- administer? Yes____ No_____

Date _____ Medical Provider's Signature _____

The undersigned hereby designates school staff who are authorized to administer the drug to the student referenced above pursuant to the written directions contained herein.

Date _____ School Principal's Signature _____

NOTE: Medication Administration Record is on the reverse side of this form.