

**PRAIRIE DU CHIEN SCHOOLS PRESCRIPTION OR OTC  
MEDICATION CONSENT FORM  
STUDENT INFORMATION:**

\_\_\_\_\_  
Student's Name Date of Birth Grade

\_\_\_\_\_  
Medication / Procedure Dosage Frequency

\_\_\_\_\_  
School Year / Effective Date Physician (PHYSICIAN SIGNATURE REQUIRED FOR PRESCRIPTION MED)

\_\_\_\_\_  
Reason for Medication / Procedure / Diagnosis

**NOTE: For prescription medications: Signed Parent consent and signed Physicians' Order are required. School nurse will fax form to physician.**

**PHYSICIAN ORDER:** Complete for each prescription / medication/ procedure at school.

The above medication/ procedure is to be administered during the school day in accordance with the above instructions.

Please contact me if the following symptoms occur:

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Does the child have any known allergies? Yes \_\_\_\_\_ No \_\_\_\_\_

If YES

list: \_\_\_\_\_

Additional

information: \_\_\_\_\_

**For asthma inhalers ONLY:** Student may carry inhaler in school? Yes \_\_\_\_\_ No \_\_\_\_\_

\_\_\_\_\_  
Date Physician's Signature Telephone / Fax

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**PARENT CONSENT: Complete with each medication / procedure at school.**

**I request that this medication / procedure be administered at school. Medication will be supplied in its 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 physician order. I authorize the school nurse/ designee to administer medication / procedure and I authorize school personnel to contact my child's physician if needed. I also release the school district from any liability claims as a result of the administration of this medication or procedure as directed.**

\_\_\_\_\_  
**Date Parent / Guardian Signature Telephone**

Please route to: Karen Reilly, R.N. School Nurse, 1901 E. Wells St., Prairie du Chien, WI, 53821  
Phone: 608-326-0503 X 3264 / Fax: 608-326-5364