

SCHOOL MEDICATION/PROCEDURE FORM
NORTH CRAWFORD SCHOOL DISTRICT
FAX 608-624-6269

STUDENT INFORMATION:			
STUDENT'S NAME	BIRTH DATE	GRADE	TEACHER
MEDICATION/PROCEDURE		DOSAGE	TIME/FREQUENCY
SCHOOL YEAR OR EFFECTIVE DATES		STUDENT'S PHYSICIAN	
REASON FOR MEDICATION/PROCEDURE			

NOTE; FOR PRESCRIPTION MEDICATION: SIGNED PARENT CONSENT AND SIGNED PHYSICIAN'S ORDER REQUIRED. FOR NON-PRESCRIPTION MEDICATION: SIGNED PARENT CONSENT REQUIRED.

<u>PARENT CONSENT:</u> COMPLETE FOR EACH MEDICATION/PROCEDURE AT SCHOOL		
<p>I request that this medication/procedure be administrated at school. Medication will be supplied in it's 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 physicians order. I authorize school personnel to contact my child's physician if needed. I release the school district from any liability claims as a result of the administration of this medication or procedure as directed.</p>		
DATE	TELEPHONE NO.	PARENT/GUARDIAN SIGNATURE

<u>PHYSICIAN ORDER:</u> COMPLETE FOR EACH PRESCRIPTION MEDICATION/PROCEDURE AT SCHOOL		
<p>The above medication/procedure is to administered during the school day in accordance with the above instructions. Please contact me if the following symptoms occur: _____ _____ _____</p> <p>Additional information: _____ _____ _____</p> <p>For Asthma inhalers ONLY – Student may carry inhaler and in school YES/NO</p>		
DATE	TELEPHONE NO.	PHYSICIAN'S SIGNATURE