SCHOOL DISTRICT OF BONDUEL

400 West Green Bay Street • P.O. Box 310
Bonduel, Wisconsin 54107-0310
http://bonduel.k12.wi.us

HIGH SCHOOL OFFICE	JUNIOR HIGH SCHOOL OFFICE	ELEMENTARY OFFICE
715-758-4850 EXT 3	715-758-4850 EXT 3	715-758-4850 EXT 2
FAX 715-997-3190	FAX 715-997-3190	FAX 715-997-3190

PARENT / GUARDIAN MEDICATION OR PROCEDURE CONSENT FORM

Student's Name	Birthdate
School	Grade
Parent's Name	Cell# _____ Home#_____ Work #_____

If **INHALER**, please check ☐ Inhaler kept with student and/or self-administer ☐ Inhaler kept in office

If **INSULIN**, please check ☐ Insulin kept with student and/or self-administer ☐ Insulin kept in office

Name of physician ordering medication or procedure: Phone number of physician:

Name of medication / dosage or procedure

Reason for medication or procedure

Hour it is to be given:	How it is to be given:

If PRN (as needed) state conditions under which school personnel should administer medication.

I hereby give my permission to the nurse or delegate(s) to give the medication or perform the procedure to my child according to the written instructions of the doctor as shown on the Physician Order Form. I also hereby agree to give my permission to the school nurse to contact the child's physician. I further agree to hold the Bonduel School District, and the Bonduel School District employee(s) who is (are) administering the medication or performing the procedure harmless in any or all claims arising from the administration of this medication or the performance of this procedure at school. I agree to notify the school at the termination of this request or when any change in the above orders is necessary.

_____
Signature of Parent/Legal Guardian Date

PHYSICIAN MEDICATION AUTHORIZATION AND INSTRUCTION

Student's Name	Birthdate

Diagnosis / Reason for Medication:

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If **INSULIN**, please check ☐ Insulin kept with student and/or self-administer ☐ Insulin kept in office

Daily Medications

Medicine	Route	Dose	Freq.	Duration Not to exceed current school year	Direct contact shall 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)
				From: To:	
				From: To:	

Physician Address (Street, City, State, Zip)

Physician's Name	Phone #:	Fax #:
Physician's Signature	Date:	

I acknowledge by my signature on this document that I will assist and advise designated school personnel with regard to the administration of the medication described above, which includes accepting direct communication. I further acknowledge that all instructions should be stated in language of the lay person. I further understand that if the student is allowed to self-administer medication that proper instruction has been given.