Manitowoc Public School District

Medication Consent Form

Student Name	Birthdate	School	Grade

Prescribing Provider	Provider Phone	Provider Fax

- I request that my child receive medication at school and I understand that it is my responsibility to obtain all required documentation and supply medication refills. Failure to do so may result in discontinuation of school-administered medication.
- I give permission for school staff to communicate with the prescribing provider regarding the medication.
- I understand that it may take up to 48 hours processing time before medication administration can begin.
- I agree to inform the school of any changes in the prescribed medication.
- I understand that it is a REQUIREMENT that all medications are transported to/from school by a responsible adult and that all medications must be in the original labeled container.
- I understand that any medications left after the last day of school will be properly disposed of by the School Nurse.
- I further agree to hold the MPSD employees harmless in all claims arising from the administration of the medication at school.

Printed Name of Parent/Guardian **Signature of Parent/Guardian** **Date**

Over the Counter (OTC) Medications (to be completed by parent)

Medication	Dose	Time	Frequency	Reason for Medication

Prescription Medications

This section to be completed by prescribing provider ONLY

Medication	Route	Dose	Time/Frequency	Administration Instructions

GRADE 6 AND UP ONLY: If an inhaler or epinephrine, may the student self-carry and administer? ☐ Yes ☐ No

Printed Name of Prescribing Provider **Signature of Prescribing Provider** **Date**