# BURLINGTON AREA SCHOOL DISTRICT

209 WAINWRIGHT AVENUE, BURLINGTON, WI 53105

(262) 763-0210

BASD.K12.WI.US

## MEDICATION ADMINISTRATION CONSENT FORM

**Student Name:** ____________________________________________ **DOB:** ________________ **Grade:** _______

**School:** _______________________________________ **Allergies**: ________________________________________

**Parent / Guardian Authorization:**
I, the parent/guardian of the above named student, have read the school's medication policy & request the medication listed below to be administered to my child at school. *I understand that I am responsible for bringing the medication to school in its original, updated, properly labeled container and for picking up any unused medication by the 2nd business day after classes conclude for the current school year* (**all medications will be disposed of after this time - no medications will be sent home with a student**). I understand that a qualified, designated person will be administering the medication & that I am responsible for maintaining a sufficient quantity at school to avoid interruptions with the MD orders. I understand that if my child refuses a prescription drug, force will not be exerted by school personnel to make them comply. I will notify the school immediately if there is a change or cancellation of the medication. The school district has my permission to contact the prescriber in regard to medications that are prescribed.

**Parent / Guardian Signature:** _______________________________________________ **Date**: ________________

===============================================================================

***NON-PRESCRIPTION (OVER-THE-COUNTER) MEDICATION PORTION: (MD signature NOT required)***

**Medication:** __________________________________ **Dosage:** __________ **Frequency:** ____________

**Time:** _____ **Route:** ______ **Reason:** ________________________ **Start Date:** ______ **End Date:** ______

===============================================================================

***PRESCRIPTION MEDICATION PORTION ONLY: (To be completed by a MD / PA /NPAP Only)***

**Medication & Dosage:** __________________________________ **Amt:** _________ **Time:** __________

**Route:** ________________ **Reason:** ______________________ **Side Effects:** ___________________

**EMERGENCY MEDICATION MANAGEMENT (Asthma Inhalers / Epi-Pens / Glucagon) :**

Student _____ CAN _____ CANNOT carry & self-administer the prescribed RESCUE INHALER

Student _____ CAN _____ CANNOT carry & self-administer the prescribed EPI-PEN

Student _____ CAN _____ CANNOT carry the prescribed GLUCAGON

**Medical Provider Signature:** ________________________________________ Date: _____________

**Address**: ____________________________________________________ Phone: ________________________