Jocelyn Hardy, Superintendent • Rich Fortier, Principal
Arbor Vitae-Woodruff Elementary
11065 Old Highway 51, Arbor Vitae, Wisconsin 54568 • 715-356-3282 • www.avwschool.org

Student Name: _____ **Birthdate:** _____ **Weight:** _____

Medication Name: _____

Reason for Medication: _____

Dose (*mg, mL, etc.*): _____

Route (*oral, inhale, injection, etc.*): _____

Time(s) to be given: _____

Entire School Year: _____ **OR** Start Date: _____ End Date: _____

PARENT/GUARDIAN: The school personnel have my permission to administer this medication/treatment as indicated above. I agree to hold the Arbor Vitae Woodruff School District, its employees and agents who are acting on this request, harmless in any and all claims arising from the administration of this medication/treatment at school. I hereby give my permission for the Arbor Vitae Woodruff School District to contact the physician/health care provider listed below with questions as they arise regarding the administration of this medication. I shall pick up unused portions of this medication within three (3) days of completion of the school year or when discontinued. I agree to notify the school in writing at the termination of this request.

Parent/Guardian's Name (print): _____ **Date:** _____

Parent/Guardian's Signature: _____ **Phone number:** _____

* Over the Counter medication **must** come in its original, small container, with expiration date evident and the child's name easily readable on the container.

FOR INHALED OR INJECTED MEDICATION ONLY:

This student is both capable and responsible for self-administering this medication:
____Yes-Supervised
____Yes-Unsupervised
____No Reason/restrictions: _____

This student may carry their inhaler/injectable medication while at school:
____Yes ____No

PRESCRIBING PRACTITIONER: Prescribing practitioner authorization is required for all medications that are prescribed, non-FDA approved or for dosages that exceed the manufacturer's recommendations. The prescribing practitioner whose signature follows hereby authorizes school personnel to administer medication/treatment as prescribed and also agrees to accept communication regarding the administration procedures.

Practitioner's Name (print): _____ **Date:** _____

Practitioner's Signature: _____ **Phone number:** _____

Prescription Medication Verification/Inventory Between Parent and Staff

Date:	Inventory:	Signature:	Signature:

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Date:	Inventory:	Signature:	Signature: