School District of Weyauwega-Fremont

410 East Ann Street, Weyauwega, WI 54983
Phone: 920-867-8840
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Weyauwega-Fremont School District

PARENT / GUARDIAN / PHYSICIAN / MEDICATION ADMINISTRATION CONSENT FORM

Wisconsin Statute 118.29 (Please type or print)

A separate form for each medication is needed.

Student Name: _____ D.O.B. _____ Grade: _____

School: Fremont Elementary Weyauwega Elementary W-F Middle W-F High School

Medication Name: _____ Prescription/Non-Prescription

Dosage: _____ Route: _____ Time: _____

Reason for Medication: _____

***If "as necessary" please list conditions under which medication should be given*:**

_____

Precautions, possible unfavorable reactions, and /or interventions: _____

Name of physician prescribing medication: _____

Signature of Physician: _____ Date: _____

A physician's written, signed statement and pharmacy labeled container must be supplied by the parent/ guardian if prescribed medication is to be given at school. All medication must be provided to the school in the original container.

I hereby give permission for designated school staff to give this medication to my child according to the directions stated above and for the school to contact my child's physician if necessary.

I further agree to hold harmless the Weyauwega-Fremont School District, its Board of Education, administration, and all employees and agents who are acting within the scope of their duties in any and all claims arising from the administration of this medication.

I agree to notify the school in writing at the termination of this request or when any change in the above order is necessary.

_____	_____	_____	_____
Signature of Parent/Legal Guardian	Date	Home Phone	Cell Phone

District Mission Statement: Creating a foundation of excellence for success in tomorrow's world.
District Vision Statement: Creating wisdom through pride, passion and honor.

MEDICATION RECORD 2019-2020

Student Name:_____D.O.B._____Student Grade:_____

Medication/Dosage/Route:_____Physician:_____

Codes:
A - Student absent
E – Error (complete a medication error report)
FT - Field trip
I - Inclement weather (no school)
N - No medication available
R - Refused
X – No school

Date	Medication	Number Rec'd	Initial

MONTH/TIME	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	RNREVIEW
SEPT. (initials)	X	X					X	X						X	X						X	X						X	X		X	
Time	X	X					X	X						X	X						X	X						X	X		X	
OCT. (initials)					X	X			X			X	X						X	X					X	X					
Time					X	X			X			X	X						X	X					X	X					
NOV. (initials)		X	X						X	X						X	X						X	X		X	X	X	X	X	
Time		X	X						X	X						X	X						X	X		X	X	X	X	X	
DEC. (initials)	X						X	X						X	X						X	X	X	X	X	X	X	X	X	X	
Time	X						X	X						X	X						X	X	X	X	X	X	X	X	X	X	
JAN. (initials)	X			X	X						X	X					X	X	X						X	X					
Time	X			X	X						X	X					X	X	X						X	X					
FEB. (initials)	X	X						X	X						X	X						X	X						X	X	X	
Time	X	X						X	X						X	X						X	X						X	X	X	
MAR. (initials)	X						X	X						X	X						X	X						X	X			
Time	X						X	X						X	X						X	X						X	X			
APR.(initials)				X	X				X	X	X	X	X					X	X						X	X					X	
Time				X	X				X	X	X	X	X					X	X						X	X					X	
MAY (initials)		X	X						X	X						X	X						X	X	X				X	X	
Time		X	X						X	X						X	X						X	X	X				X	X	
JUNE (initials)																																
Time																																

Staff administering medication initials/name: _____ _____ _____

_____ _____ _____