

**SCHOOL DISTRICT OF RHINELANDER  
PHYSICIAN AND PARENT REQUEST FOR SCHOOL  
ADMINISTRATION OF PRESCRIPTION MEDICATION (WISCONSIN STATUTE 118.29)**

Student: \_\_\_\_\_ DOB: \_\_\_\_\_  
School: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

**TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED HEALTH CARE PROVIDER**

Reason for the medication:

\_\_\_\_\_

Name of the Medication:

\_\_\_\_\_

\_\_\_\_ tablet/capsule \_\_\_\_ liquid \_\_\_\_ inhaler \_\_\_\_ injection \_\_\_\_ nebulizer \_\_\_\_ other

Instructions (schedule and dose to be given at school):

\_\_\_\_\_

Duration:

School Year 20\_\_ - \_\_ (including summer school) OR From \_\_\_\_\_ To \_\_\_\_\_

Restrictions and/or important side effects: \_\_\_\_ none-anticipated please describe \_\_\_\_\_

Special storage requirements: \_\_\_\_ none \_\_\_\_ refrigerate \_\_\_\_ other

**FOR INHALED MEDICATION ONLY:**

This student is both capable and responsible for self-administering this medication:

\_\_\_\_ no \_\_\_\_ yes-supervised \_\_\_\_ yes unsupervised

This student may carry this inhaler while at school: \_\_\_\_ yes \_\_\_\_ no

Please indicate if you have provided additional information: \_\_\_\_ on back of form \_\_\_\_ attachment

The physician/health care provider whose signature follows hereby authorizes school personnel to administer medication/treatment as prescribed and also agrees to accept communication regarding the administration procedures. It is understood that non-licensed, trained personnel will give the medication/treatment and the provider gives the reason why the medication/treatment must be given during the day. Temporary orders from medical personnel written on prescription pads or faxed will be accepted for a period of seven (7) days from the date of the order. The student per section 118.291(Wis.Stats.) may carry prescription inhalers with written signature from the physician/nurse practitioner and the student's parent/guardian.

Physician signature: \_\_\_\_\_

Printed name

Signature

Date

Address/Phone number:

\_\_\_\_\_

The school personnel have my permission to administer this medication/treatment as indicated above. I agree to hold the School District of Rhinelander, its employees or 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 School District of Rhinelander to contact the physician/health care provider listed above to contact the physician with questions as they arise to the administration of this medication.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date