LAKELAND UNION HIGH SCHOOL

9573 State Hwy 70 • Minocqua, Wisconsin 54548-9000 • www.luhs.k12.wi.us

LUHS PARENT/GUARDIAN MEDICATION CONSENT, RELEASE OF INFORMATION AUTHORIZATION AND PHYSICIAN MEDICATION ORDER FORM

Student Name:____________________________ **Date of Birth:**____________ **Grade:** ______

Address: ________________________________ **Phone:** ____________________

Name of Physician Prescribing Medication: ____________________________________

MD Office Address:____________________________ **Phone:** ____________________

PARENTS

I hereby give permission to the Lakeland Union High School Nurse or his/her designee to give the medication(s) as listed below to my child according to the directions stated below. I agree to hold the Lakeland Union High School District and its employees, who are acting within the scope of their duties, harmless in any and all claims arising from the administration of this medication at school.

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

I further authorize the school nurse permission to correspond with the child's physician in regards to the medication order(s) below and the associated diagnose(s) in which the medication has been ordered for. (Permission will remain in effect from this date until revoked by signer)

I further authorize that medications may be given to the student as ordered below during field trips sponsored by the school.

________________________________ ____________________

Signature of Parent/Legal Guardian **Date**

SCHEDULED DAILY MEDICATION(S) AS ORDERED BY PHYSICIAN					
Medication Name	**Dose**	**Route**	**Frequency**	**Duration**	**Diagnoses**
Example only: Adderall XR	30mg capsule one	by mouth	Once a day at 8 AM	School year 20__-20__ or specify	Attention Deficit

PRN (As Needed) MEDICATION(S) AS ORDERED BY PHYSICIAN					
Medication Name	**Dose**	**Route**	**Frequency**	**Duration**	**Diagnoses**
Example only: Ventolin Inhaler	90 mcg---puffs 1-2	by mouth	Every 4-6 hrs. as needed	School year 20__-20__ or specify	Respiratory Difficulty: Asthma

PHYSICIAN

I hereby acknowledge and order the above listed medication(s) to be given during school hours at LUHS to the student as named above. Direct contact shall be made with me should the student receiving the medication develop adverse reactions to the medication(s). These orders will remain in effect until duration of medication is complete or until completion of this school year.

❑ By checking box I allow the student to carry his / her own respiratory inhaler for an asthma attack or Epinephrine pen for severe allergic reaction on person at school for use as ordered and directed above.

________________________________ ____________________

Signature of Physician **Date**

PLEASE FAX COMPLETED FORM TO LUHS -ATTN: NURSE AT 715-358-2905

This is a confidential FAX line directly to nurses office.