MEDICATION/TREATMENT REQUEST
Martin Luther Christian School

Please check: □ Medication □ Treatment

All portions of this Medication/Treatment Request form must be completed before medication can be administered by school personnel. Incomplete forms may result in the form being returned for full completion.

Student_____School_____

Child's Date of Birth_____Grade_____Teacher_____

Name of Medication_____

Describe Treatment and Procedure_____

_____

Dosage_____Times(s) to be given_____

How to be given_____
oral,injection,inhalation (other)

Reason For Medication_____ Date of Discontinuation_____

Explain possible reactions or other instructions_____

_____

Health Care Provider's Name_____Healthcare Provider's Phone #_____
(please print)

The school personnel have my permission to administer this medication/treatment as indicated above.
I agree to hold Martin Luther Christian School, 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 also agree to inform the school immediately and in writing of any change or discontinuation of this order. I shall pick up unused portions of the medication/treatment within 3 business days of completion of the school year or when this order has been discontinued. I acknowledge that the medication/treatment supplies will be destroyed if it has not been picked up after a 10-day period following notification.

_____ _____ _____ _____
Parent/Guardian Signature | Date | Home Phone No. | Work Phone No.

HEALTHCARE PROVIDER AUTHORIZATION

The healthcare provider whose signature follows hereby authorized school personnel to administer medication/treatment as prescribed and also agrees to accept communication regarding the administration procedures. It is understood that the medication/treatment will be given by non-licensed, but specially trained personnel, and the reason(s) that the medication/treatment must be given during the school day should be given. Temporary order (except controlled substances) from healthcare providers written on prescription pads or faxed will be will be accepted for a period of seven days from the date of the order. Prescription inhalers may be carried by the student per section 118.291 (Wis. Stats.) with a written signature from healthcare provider and parent/guardian.

Medical rationale for medication/treatment to be given during the school day: _____

_____

_____ _____ _____
Healthcare Provider's Signature | Phone Number | Date