Kiel Area School District
Prescription Medication Consent Form
With Physician's Order for Administration

Student _____ Date _____

School _____ Grade _____ Date of Birth _____ Age _____

Physician _____ Hospital/Clinic/Office _____

Physician's Phone No. _____

Physician:
In order for school personnel to administer the medication regime you have prescribed, please complete the following form.

Student's Diagnosis for Medication _____

Name of Medication	Dosage (tsp., tablet)	Approximate Time of Dosage	Side Effects

Please indicate if the medication above is PRN (to be taken as needed): _____

Conditions under which PRN medication should be given: _____

_____

*Physician's Signature _____ Date _____

***Must Be Signed by the Physician**

Parent/Guardian
(Please fill out this portion of the form after your child's physician has completed the top, and return this form to the school office.)

I hereby give my permission to school personnel designated by the school principal to give medication to my child according to the written instructions of the physician as shown above.

I further agree to hold the Kiel Area School District and all employees 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 above is necessary. (Please note any medication brought to school should be in a labeled pharmacy container. Controlled substances must be transported by an adult. I will be responsible for bringing in medication when container becomes empty, otherwise no medication will be distributed.) I also hereby agree to give my permission to the school nurse to contact the child's physician.

Signature of Parent/Legal Guardian _____

Address _____

Phone _____