Middleton High School
2100 Bristol Street – Middleton, WI – 53562
Health Office – 608.829.9687   FAX – 608.831.7920
MIDDLETON HIGH SCHOOL - MEDICATION ADMINISTRATION INFORMATION

Student: _____ Birthdate: _____ Grade: 9   10   11   12
                                                                                                (Circle one)

Guardian: _____ Phone: _____

PRESCRIPTION MEDICATION
Controlled substance medications **cannot** be carried by students.

Diagnosis:_____

Medication	Dose	Route	Time	Start Date	End Date	Side effects to report to practitioner

Please indicate if student may carry and self administer the medication(s).   _____ Yes   _____ No

Practitioner* Name: _____ Phone: _____

Practitioner Signature: _____ Date: _____

*Definition of practitioner: physician, physician assistant, advanced practice nurse, optometrist, dentist, podiatrist or chiropractor.

NON-PRESCRIPTION MEDICATIONS
Non-prescription medication will only be administered in accordance with product instructions. If the student requires dosing different than manufacturers instructions, a practitioner order AND signature is required.

Medication	Dose	Frequency	Start Date	End Date

Guardian, please **check one** of the following statements:

_____ Authorized school personnel have my permission to administer the prescription and/or non-prescription medication(s) to my child as described above.

_____ My child has my permission to carry and self-administer the above prescription and/or non-prescription medication(s).

I agree to hold Middleton Cross Plains Area School District, its employees and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of medication as described above at school. I hereby give permission to the school nurse to contact the physician as needed.

I understand that for safety reasons, ALL medication (prescription or non-prescription) has to be in the original container. I further understand it is my responsibility to inform the school nurse of any changes to my child's medications.

Guardian Signature: _____ Date: _____

School Nurse Approval:_____ Date: _____