Capitol West Academy
3939 North 88th Street
Milwaukee, Wi 53222
Phone: 414-465-1302
Fax: 414-465-1302

Parent / Guardian Medication Consent Form 2017-18

Please type or print. It is essential that this is clearly legible.

Full name of child to be medicated: _____

Grade and Homeroom: _____

Name of drug and dosage: _____

Hour(s) medication is given: _____ Number of Days: ____

Name of physician prescribing medication: _____

Physician's phone number: (_____) _____

I hereby give permission to the Health Room/ Office Personal to give the medication(s) to my child according to the directions stated above and further authorize them to contact the child's physician. I agree to hold Capitol West Academy, its employees, and the agents 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 changes in the above order is necessary.

_____ _____
Signature of Parent/ Legal Guardian Date

_____
Address City State Zip Code

(_____) _____ (_____) _____ (_____) _____
Home Phone Work Phone Cell Phone

Please complete this form and return it with the medication(s) to the school office.

- over -

Revised November 2016

PHYSICIAN REQUEST AND AUTHORIZATION

Please type or print. It is essential that this is clearly legible.

Name of student: _____

Home phone: (_____) _____ Student age: _____ Student grade: _____

Diagnosis : _____

PHYSICIAN MEDICATION ORDERS:

Daily Medications Name of Medication	Route	Dose	Frequency	Duration	Direct contact shall be made with me should the student receiving the medication develop any of the following conditions or reactions to the medication:
				From: To:	
				From: To:	
				From: To:	
PRN Medications (AS NEEDED) Name of Medication	Route	Dose	Frequency	Duration	Direct contact shall be made with me should the student receiving the medication develop any of the following conditions or reactions to the medication:
				From: To:	
				From: To:	
				From: To:	

The information on this form constitutes my physician medication orders for the subject student. I agree to retain the power to direct, supervise, decide, inspect, and oversee the administration of such medication(s). Direct contact shall be made with me at the time should you have any questions.

Hospital/ Clinic/ Office: _____

Address: _____ City: _____ State: _____ Zip code: _____

Physician's Signature: _____ Phone : (_____) _____

Date: _____

Revised November 2016