Wausau School District
Medication Administration Consent Form

Student Name: _____DOB:_____
Parent/Guardian: _____
Home Phone: _____Work:_____Cell:_____
Health Care Provider: _____Phone:_____

***Individual action plans* will be used for medication orders for the following conditions:**
Asthma Severe Allergies Diabetes Seizures

Medication Name:_____
Administration Instructions: _____
_____
Effective Date: _____To:_____

Medication Name: _____
Administration Instructions: _____
_____
Effective Date: _____**To:**_____

Medication Name: _____
Administration Instructions: _____
_____
Effective Date: _____**To:**_____

- **For students carrying rescue medication, it is recommended that an additional (back-up) medication be available in the health office.**

Practitioner signature -Directs the above medication administration and indicates a willingness to communicate with staff who administers the medication.
Parent signature -Allows staff to give the above medication and to contact the health care provider if necessary.

Comments: _____
_____

Health Care Provider Signature: _____ Date: _____

Parent Signature: _____ Date:_____