

Student Health Form

Medication Policy

Student's Name: _____

Prescription Medication

Please keep the medicine in its original packaging and have it clearly labeled with your child's name.

____ My child has my permission to keep and take their own prescription medications. No student will use a prescription medication prescribed for another student.

**If you select this option...be sure to complete the:
STUDENT SELF-ADMINISTER MEDICATION FORM**

Green Sheet

____ My child's prescription medication(s) will be kept by the medical person, or their designee (usually a head chaperone for the trip) to be dispensed in accordance with the prescription label, and recorded in the medical log. The medication will be provided in the original prescription bottle/package, with the prescription label identifying the child, the medication, and dosage information.

**If you select this option...be sure to complete the:
PRESCRIPTION MEDICATION ADMINISTRATION CONSENT FORM**

Pink Sheet

Over The Counter Medication

Please keep the medicine in its original packaging and have it clearly labeled with your child's name.

____ My child may take over the counter medications at their own discretion, s/he is responsible for the time and quantity of medicine being taken.

**If you select this option...be sure to complete the:
STUDENT SELF-ADMINISTER MEDICATION FORM**

Green Sheet

____ I prefer my child is given medicine by a chaperone and recorded in the medical log.

**If you select this option...be sure to complete the:
NON-PRESCRIPTION
(OVER THE COUNTER)
MEDICATION ADMINISTRATION CONSENT FORM**

Beige Sheet

____ My child understands that s/he is NOT to share ANY medicine with other students, including over the counter medicine such as ibuprofen or aspirin.

Student Signature: _____ Date: _____

Parent Signature: _____ Date: _____

Student Health Form

Medical Form Instructions

Side 1 (Medical Information)

- Please complete this to your comfort level. In the event of an emergency or medical situation, this sheet would be used as a quick reference guide. The information on this sheet would expedite medical service in a worse-case scenario. You can complete the entire form or only the portions you are comfortable with. Forms will be returned to you after the trip.

Side 2 (Medication Policy)

Prescription Medications

- If your child takes prescription medication, you have two choices.
 1. Your child can hold on to his/her medicine and be responsible for self-administering the medication. You need to fill out the green sheet if you select this.
 2. Mr. Sveum can hold the medicine and will administer the medication according to the prescription. Time and dosage will be logged throughout the week. You need to fill out the pink sheet if you select this.

Over the Counter Medications

- If your child brings over-the-counter medication, you have two choices.
 1. Your child can hold on to his/her medicine and be responsible for self-administering the medication. You need to fill out the green sheet if you select this.
 2. Mr. Sveum can hold on to the medicine and will administer the medication according to the prescription. Time and dosage will be logged throughout the week. You need to fill out the beige sheet if you select this.

ALL STUDENTS

- If you are NOT taking prescription medication and do NOT plan on bringing any over-the-counter medication...you still need to put an "X" on the agreement that you will NOT share any medicine along with both parent/guardian and student signature! (Often times students do not bring medicine but might buy medicine throughout the week)
- Please sign both sides of the form even if you filled out little or nothing on the form. This acknowledges you received the form and had the opportunity to list information.
- Please provide the completed form(s) to Mr. Sveum by May 1.

Student Health Form

Student's Full Name _____ Male _____ Female _____

Present Grade _____ Age _____ Date of Birth _____

Address _____

<input type="checkbox"/> Father <input type="checkbox"/> Stepfather (check one) Name _____ Address _____ Home Phone _____ Business Phone _____	<input type="checkbox"/> Mother <input type="checkbox"/> Stepmother (check one) Name _____ Address _____ Home Phone _____ Business Phone _____
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Student Lives With _____

Health History

(please list dates where known)

Hospitalization or Operation (within last two years): _____

Emotional Problems (i.e. hyperventilates, hysteria): _____

Serious Medical Problems (i.e. Diabetes, Epilepsy, Migraine): _____

Allergies (i.e. hay fever, food, asthma, other): _____

Tetanus (Date of last injection): _____

Any Special Health Problems In The Past? _____

Allergy to drugs (i.e. penicillin, insulin, aspirin, etc...) _____

Any specific drugs your child
should not take? (including non-prescription) _____

Is child under medical treatment at present? _____ (reason) _____
(i.e. tranquilizer, antihistamines, asthma, etc... give doses and frequencies)

Family Physician: _____ Phone: _____

Address: _____ Local Hospital Preference: _____

Family Dentist: _____ Phone: _____

Emergency Contact and Insurance

In case parent cannot be reached in the event of an emergency:

Name _____ Phone: _____

Address: _____

Insurance Company & Address: _____

Policy #: _____ Group # _____

Primary Carrier _____ (please state if mother's or father's carrier)

Employer Name: _____

Student's Social Security Number: _____

Student Signature: _____ Date: _____

Parent Signature: _____ Date: _____

SUN PRAIRIE AREA SCHOOL DISTRICT
501 South Bird Street
Sun Prairie, WI 53590



**STUDENT SELF-ADMINISTER MEDICATION FORM
FOR STUDENTS GRADES 10-12**

Student name: _____ Parent/Guardian name: _____

Phone # _____ School: _____ Grade: _____ DOB _____

I request that my child be permitted to carry his/her own prescription medication. He/she has been instructed in and understands the purpose and appropriate method and frequency of medication use.

Medication must be brought to school in the original container labeled with the student's name.

When a student is responsible for administering his/her own medication, the school bears no responsibility for safeguarding the medication or assuring that it will be taken. The District may revoke this privilege if the student abuses this privilege by sharing, selling, or not taking the medication as directed

My child may carry the following medications:

Name and Strength of Medication	Dose	Time to be Taken

Signature of Parent/Legal Guardian

Date

SUN PRAIRIE AREA SCHOOL DISTRICT

501 South Bird Street
Sun Prairie, WI 53590

PINK

**PRESCRIPTION
MEDICATION ADMINISTRATION CONSENT FORM**
(Please print clearly)

Student name: _____ Parent/Guardian name: _____
Phone # _____ School: _____ Grade: _____ Age: _____

PRACTITIONER SECTION

Practitioner name: _____ Phone #: _____

Diagnosis: _____

Name of medication & strength (e.g. mg.): _____ Time to be given: _____

Dose & route of administration: _____

Reason for medication: _____

Duration: From _____ to _____

For an as-needed (PRN) medication, state specific conditions under which medication is to be given:

State the side effects for which we should contact you:

NOTE: Your signature on this document attests to your willingness and intent to direct, supervise, decide, inspect and oversee the administration of the medication by non-medically trained designee(s) and that you will accept direct communications from them regarding the administration of the medication. We urge that all instructions be stated in language of the lay person. Any changes to this order must be in written form.

Practitioner's Signature _____ Date _____
=====

PARENT/LEGAL GUARDIAN SECTION

I hereby give my permission to the Sun Prairie Area School District to administer medication to my child according to the directions stated above and further authorize them to contact the child's practitioner if warranted (should the need arise for the safety of my child and other students). I agree to hold the Sun Prairie Area School District, its employees and agents who are acting in good faith and within the scope of their duties harmless from any and all claims arising from the administration of this medication at school.

I will notify the school in writing whenever this consent is withdrawn prior to the end of the duration period stated above.

Signature of Parent/Legal Guardian _____ Date _____

NOTE: Person(s) who will be administering medication during school hours are listed in the principal's office. Before a medication will be administered by the school or agent thereof, this form shall be completed and returned to the school principal who shall file and retain the same. Medications must be in their original containers with the following information printed on the container: 1) Student's full name; 2) Name and dosage of the medication; 3) Time to be given; 4) Practitioner's name.

JHCD-E(1) (Maintained by Administration)
Adopted by the School Board: October 1995
Revised by the School Board: October 1998
Delegated to Administration: January 11, 1999
Updated: February 25, 2003

SUN PRAIRIE AREA SCHOOL DISTRICT
501 South Bird Street
Sun Prairie, WI 53590

BEIGE

**NON-PRESCRIPTION
(OVER THE COUNTER)
MEDICATION ADMINISTRATION CONSENT FORM**
(Please print clearly)

Student name: _____ Parent/Guardian name: _____

Phone # _____ School: _____ Grade: ____ Age: ____

Practitioner name: _____ Phone #: _____

Name of medication & strength (e.g. mg.): _____ Time to be given: _____

Dosage: _____

Reason for medication: _____

Duration: From _____ to _____

I hereby give my permission to the Sun Prairie Area School District to administer medication to my child according to the directions stated above and further authorize them to contact the child's practitioner if warranted (should the need arise for the safety of my child and other students). I agree to hold the Sun Prairie Area School District, its employees and agents who are acting in good faith and within the scope of their duties harmless from any and all claims arising from the administration of this medication at school.

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Signature of Parent/Legal Guardian

Date

NOTE: Person(s) who will be administering medication during school hours are listed in the principal's office. Before a medication will be administered by the school or agent thereof, this form shall be completed and returned to the school principal who shall file and retain the same. Medications must be in their original containers with the following information printed on the container: 1) **Student's full name**; 2) **Medication name and dosage/time to be given**.

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