

## MEDICATIONS

### CONSENT FORMS ARE ATTACHED – PLEASE COPY AS NEEDED

**SCHOOL NURSE SERVICES** – If you would like your children to have school nursing services, please complete the Children's Hospital consent form. These services include physical examination, health screening and treatment for illness or injury. The school nurse will be available for a few hours most days. Please see the attached form for more information. These services, provided through Children's Hospital, are separate from the capabilities of the school office personnel.

**PRESCRIPTION MEDICATION** – If these must be dispensed during the school day they must be accompanied by the proper form completed by the doctor.

**OVER-THE-COUNTER-MEDICATION** – If these must be dispensed during the school day they must be accompanied by the proper form completed by a parent. All medications must be their original container.

These medication consent forms have been created by the Archdiocese of Milwaukee and we have been instructed to use them exclusively. Each family receives these forms at the beginning of the school year and are encouraged to make copies for their use throughout the school year. When you have a doctor appointment, please be certain to take a form with you in the event that medication is prescribed. Additional forms are available in the school office.

**MEDICATION CANNOT BE DISPENSED WITHOUT THESE COMPLETED FORMS. ALL MEDICATIONS, BOTH PRESCRIPTION AND OVER-THE-COUNTER, MUST BE KEPT IN THE SCHOOL OFFICE. MEDICATION CANNOT BE KEPT IN THE CLASSROOM.**

- Medication must in original container.
- The student and parent assume full responsibility for the student to report to the office at the designated time that medication is to be dispensed.
- If a student needs to take medication during the school day, and we do not have proper written permission, the parent will need to come and dispense the medication. Neither handwritten nor verbal instruction from a parent is acceptable.

**ASTHMA INHALERS** – We recognize the importance and necessity of students being allowed to carry asthma inhalers. Inhalers may be kept in the office with the completed prescription form, or the student may self-administer under the supervision of the school staff. The Inhaler Release form states that the student has been instructed in and understands the purpose, appropriate method and frequency of use of his/her inhaler. The school is absolved from any responsibility in safeguarding the student's inhaler.

# OVER THE COUNTER MEDICATION

## PARENT/GUARDIAN MEDICATION CONSENT FORM (Please type or print)

Full name of child to be medicated: \_\_\_\_\_

Name of drug and dosage: \_\_\_\_\_

Hour(s) medication to be given: \_\_\_\_\_ Number of Days: \_\_\_\_\_

Name of physician prescribing medication: \_\_\_\_\_ Phone: \_\_\_\_\_

Reason for medication: \_\_\_\_\_

Name of person(s) who will be giving medication during school hours: \_\_\_\_\_

Principal or Principal's designee

(to be filled out by school principal or nurse)

I hereby give permission to the above named persons 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 the School, its employees and 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 change in the above order is necessary.

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Address

# PRESCRIPTION MEDICATION

SAINT SEBASTIAN SCHOOL  
1747 N. 54th Street  
Milwaukee, WI 53208  
Phone: 414-453-5830 Fax: 414-453-9449

TO BE FILLED OUT BY PHYSICIAN

Dear Principal or Principal's designee  
Individual(s) Administering Medication

Please administer the following medication(s) to:

Name of Student \_\_\_\_\_ Address: \_\_\_\_\_

Student Telephone No. \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_

Diagnosis \_\_\_\_\_

Physician Medication Orders:

### DAILY MEDICATIONS

Medicine	Route	Dose	Frequency	Duration
				From: To:
				From: To:
				From: To:

Direct contact shall be made with me should the student receiving the medication develop any of the following conditions or reactions to the medication (if none, so state).

### PRN MEDICATIONS (as is needed)

Medicine	Route	Dose	Frequency	Duration
				From: To:
				From: To:
				From: To:

Condition under which medication should be given

Direct contact shall be made with me should the student receiving any medication develop any of the following conditions or reactions to the medication (if none so state).

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 any time should you have any questions.

Hospital/Clinic/Office: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Saint Sebastian School  
1747 N. 54th Street  
Milwaukee, WI 53208  
Phone: 414-453-5830 Fax: 414-453-9449

**Archdiocese of Milwaukee**

**Release Form for Student Inhaler Use**

**Parents:**

Please ensure that all signatures necessary to implement this "Inhaler Use" form are in place on this form before submitting it to the school office.

Date: \_\_\_\_\_

\_\_\_\_\_ has been instructed in the proper use of the below listed  
(Child's Name)  
inhaler \_\_\_\_\_

We, \_\_\_\_\_, and \_\_\_\_\_ request  
(Physician) (Parent/Legal Guardian)

that \_\_\_\_\_ be permitted to carry the inhaler on his/her person, or to keep same in his/her classroom or locker, as we consider this student to be responsible.

He/she has been instructed in, and understands the purpose and appropriate method and frequency of use of the inhaler.

We, the undersigned physician and parent/legal guardian absolve the school and its employees, agents and officers of any responsibility in safeguarding our child's inhaler.

\_\_\_\_\_  
(Physician's Signature)

\_\_\_\_\_  
(Parent/Legal Guardian's Signature)

\_\_\_\_\_  
(School Principal's Signature)

\_\_\_\_\_  
(Homeroom Teacher's Signature)

**St. Sebastian's 8<sup>th</sup> Graders Invite YOU  
to enjoy PIZZA and a PACKERS Game  
for a PURPOSE**

**Sunday, September 12<sup>th</sup>  
4 PM - 9 PM**

## **Pizzeria Piccola**

**Dine In: 7606 W. State Street, Wauwatosa, WI 53226  
Take Out and Delivery (for Tosa): (414) 443-0800**

order online at [www.pizzeriapiccola.com](http://www.pizzeriapiccola.com)

●  
**A Fundraiser for  
St. Sebastian's  
8<sup>th</sup> Grade Trip to  
Washington, DC**  
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