Form 5330 F1

LOMIRA SCHOOL DISTRICT

Physician's Order for Administration of Medication

This order for medication is required to be completed and presented to the school a child attends before any prescription drug may be administered to the child. (Wisconsin Statutes 118.29 (2)(a)(2).)

Student's Name _____ D.O.B. _____ Gender___(M)____(F) School _____ Grade_____
Parent's Name_____ Address_____ Phone_____
Physician's Name _____ Physician's Address _____ Phone _____
Diagnosis _____

NO MEDICINE WILL BE GIVEN UNLESS IT IS IN THE ORIGINAL CONTAINER

- Physician please note: For the safety of our students, standard medication times are 7:45 am and lunch hour. Only when absolutely necessary indicate times outside of these standardized times for medication to be given.

Medication	Dose	Time to be Given			Duration (list dates)		Physician: Please list conditions or adverse reactions indicating parental and/or physician notification.	PRN (as needed medication) Indicate conditions under which medication should be given.
		7:45 AM	**Lunch Hour**	**Other** (list time)	**Start**	**Finish**		

Physician's Signature _____ Date _____

PARENT/GUARDIAN CONSENT FORM

I hereby give permission to school personnel to give 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 Lomira School District, its employees and agents who are acting within the scope of their duties harmless (Wisconsin Statutes 118.29 (2)(a)(1)(2)(3)(b).)
I agree to notify the school in writing when any change in the above order is made.

Signature of Parent/Guardian _____ Date _____

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