School District of Flambeau
HOME OF THE FALCONS
N4540 County Highway I, PO Box 86, Tony, Wisconsin, 54563
P: 715-532-3183
F: 715-532-5405

Health Office Phone: 715-532-4722 Nurse Phone 715-532-3183 ext. 4506
Fax: 715-532-9090

MEDICATION REFILLS

The School District of Flambeau requests that parents/guardians bring medication to the Health Office. If you are not able to bring the medication to school please call/email to notify us that the student needs a locked medication bag to bring home.

The following form must be completed and sent back to school with the medication. Your child should return medication to the Health Office when first arriving at school, and should not be kept by the student or in the student's backpack, jacket, locker, etc.

To Be Completed by Parent/Guardian

Student Name:		Date of Birth:
Name of Medication:	Dose of Medication:	Number/Amount Sent to School:
Parent/Guardian Signature:		Date:

To Be Completed by School Staff

Medication Amount Received Matches Amount Sent: ☐ Yes ☐ No	Comments:
School Staff Signature:	Date:

School District of Flambeau
Authorization for Administration of Prescription Medications

Health Office Phone: 715-532-4722 Nurse Phone: 715-532-3183 ext. 4506 Fax: 715-532-9090

Name of student:	DOB:	Grade:

Physician Section

Name of medication:		
Dosage:	Route:	Frequency:
Beginning date:		Termination date:
Reason for medication:		
Conditions which warrant immediate contact with this physician:		
For asthma inhalers, insulin and glucagon injections, and epinephrine pens ONLY. Students may carry and self-administer medication during School District of Flambeau and at school events. Yes ☐ No ☐		
As the physician prescribing this medication, I will be willing to have contact and accept direct communication with the person(s) administering this medication. Physician's Signature: _____ Date:_____		

Parent Section

- I give permission and release from liability the School District of Flambeau person(s) designated to administer the prescribed medication according to the physician's directions.
- I understand that this medication must be sent to school in the original prescription container with a copy of this completed form with appropriate signatures must be on file in the Special Services Office.
- I will notify the school in writing of any medication changes and will obtain a new physician's order. I understand that any unused medication must be picked up from the school within two weeks of termination or at the end of the school year or it will be disposed of.
- I will be responsible for delivering to and retrieving the medications from the Special Services Office.
- I authorize school personnel to contact my child's physician if needed.

Parent/Guardian Signature:_____ Date:_____

SCHOOL DISTRICT OF FLAMBEAU

AUTHORIZATION FOR ADMINISTRATION OF NON-PRESCRIPTION MEDICATIONS

Health Office Phone: 715-532-4722 Nurse Phone: 715-532-3183 ext 4506 Fax: 715-532-9090

STUDENT:	DOB:	GRADE:

Parent/Guardian/Physician

NAME OF MEDICATION:		
DOSAGE:	ROUTE:	FREQUENCY:
BEGINNING DATE:		TERMINATION DATE:
REASON FOR MEDICATION:		
CONDITIONS WHICH WARRANT IMMEDIATE CONTACT WITH THIS STUDENT'S PHYSICIAN:	PHYSICIAN'S CONTACT INFORMATION IF NECESSARY:	

I give permission and release from liability the School District of Flambeau person(s) designated to administer the medication according to the instructions on the bottle or the physician's directions (whichever is applicable).

I understand that this medication must be sent to school in the original bottle with a copy of this completed form including parent/guardian signature.

I will notify the school in writing of any change in directions.

I will be responsible for delivering to and retrieving from the school medications stored in the Pupil Services Office. I understand that any unused medication must be picked up from the school within two weeks of termination or at the end of the school year when it will be disposed of.

I authorize school personnel to contact my child's physician if needed.

Parent/Guardian Signature:_____Date:_____