OCONOMOWOC AREA SCHOOL DISTRICT
Quality Schools for a Growing Future

District Nurse Phone: 262-560-2104
District Nurse Fax: 262-560-2106

Medication Change/Stop Form

Student Name: _____

Student Date of Birth: _____

Name of Medication: _____

Prescribing Physician (also noted on original consent form): _____

Stop/Change Date: _____

School: _____ **School Year**: _____ _____

Change (please indicate which change below)

- ○ Discontinue Medication: my child will no longer receive this medication
- ○ Discontinue Medication at School: my child will take this medication at home
- ○ Medication Change: my child will be taking a different medication (new consent form needed)
- ○ Dose Change: will now receive _____
- ○ Time Change during School Hours: will now take medication at _____

Parent Name (please print):_____

- I hereby give permission to OASD's trained staff to give the medication(s) to my child according to the directions stated above and further authorize them to contact the child's physician with any concerns regarding medication administration. I agree to hold the Oconomowoc Area School District, 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 allow the named physician (office) to send by electronic transmission this form to the Oconomowoc Area School District for the purpose of continuing health care at school.
- I give the school staff, including the district designated health care professional, permission to call me with any concerns regarding medication administration.

Parent Signature: _____

Date: _____

Physician Name (please print): _____

Physician Signature: _____

Date: _____