



Name	_____	School Year	_____
Birthdate	_____	School	_____
	_____	Grade	_____
Physician	_____	Physician phone #	_____

The following information is helpful to your child's District Nurse and school staff in determining any special needs your child might require. Please answer the questions to the best of your ability. If you desire a conference with the District Nurse, please call 262-238-5663 OR 262-238-7932 for an appointment.

The condition(s) listed below are no longer an issue for my child. (Please sign and return Care Plan)

Medical condition(s): _____

Usual treatment: _____

Signs of emergency: _____

Actions for teacher to take: _____

Please see next page for more information.

Student Name: _____ School and Year: _____

Medication	Dosage	Time(s)	Taken at home or school

*****Please supply the school with the needed medication(s) on or prior to the first day of school*****

My child does not take any medication at home or at school

- I hereby give permission to MTSD'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 Mequon-Thiensville 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 Mequon-Thiensville 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/Guardian Signature **Date**

→ _____
Physician Signature *(if prescription medication to be given at school)* **Date**

District Nurse Signature **Date**