

Parent/Guardian Medication or Procedure  
Consent Form

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A doctor's written instructions for using the medication, dosage, or procedure must accompany this form.

Date \_\_\_\_\_

Child's name \_\_\_\_\_ Grade \_\_\_\_\_

School \_\_\_\_\_ Date of birth \_\_\_\_\_

Name of physician ordering medication or procedure \_\_\_\_\_

Phone number of physician \_\_\_\_\_

Address of physician ordering medication or procedure (street, city, state, ZIP)

\_\_\_\_\_

Name of medication or dosage or procedure \_\_\_\_\_

Reason for medication or procedure \_\_\_\_\_

Hour(s) it is to be given: \_\_\_\_\_

How it is to be given: \_\_\_\_\_

I hereby give my permission to the nurse or delegate(s) to give the medication or perform the procedure to my child according to the written instructions of the doctor. I also hereby agree to give my permission to the school nurse to contact my child's physician.

I further agree to hold Capitol West Academy and the CWA employee(s) who is (are) administering the medication or performing the procedure harmless in any or all claims arising from the administration of this medication or the performance of this procedure at school.

I agree to notify the school at the termination of this request or when any change in the above order is necessary.

Parent/Guardian Signature \_\_\_\_\_ Signature date \_\_\_\_/\_\_\_\_/\_\_\_\_

Child's Name \_\_\_\_\_ Grade \_\_\_\_\_

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**118.13 Pupil discrimination prohibited.** (1) No person may be denied admission to any public school or be denied participation in, be denied the benefits of or be discriminated against in any curricular, extracurricular, pupil services, recreational or other program or activity because of the person's sex, race, religion, national origin, ancestry, creed, pregnancy, marital or parental status, sexual orientation or physical, mental, emotional or learning disability.