

SHEBOYGAN COUNTY STUDENT MEDICATION AUTHORIZATION FORM

Dear Parent or Guardian:

Medications should be administered to students by their parents/guardians at home whenever possible. In the event this is not possible, proper written consent must be given to designated school personnel to administer medication. Each medication requires a separate authorization form.

For Nonprescription Medications:

Parent/Guardian written authorization is required.

For Prescription Medications:

Parent/Guardian written authorization and practitioner written authorization is required.

No medication will be administered by school personnel or its agents until the consent forms are completed and on file with the school. Medication authorization and administration forms will be kept and stored confidentially as required under Wis. Stat. 118.29(4).

All medication must be in the **original container** labeled with the student's name, correct dosage, time and quantity to be given. All prescription medication must be in the **original container** labeled from the pharmacy. All medication will be kept in a securely locked cabinet or storage area only accessible to those who have been given authority to administer medications to students.

Parents are responsible for bringing medication to school and picking up unused medication within 10 days after the medication is discontinued. Students are not allowed to transport medication from school. School personnel who administer medication to students will have been provided orientation and training. By law, school personnel may not cut tablets. If your child needs to receive half a tablet, have this done at home or by the pharmacy filling the prescription. Current school policy does not allow non-FDA approved drugs (herbal medication) to be administered at school.

Students who self administer medication need to have a medication authorization form on file at school. It is recommended students carry no more than one week of medication at a time.

In accordance with the standards of nursing practice, the school nurse may refuse to administer or allow to be administered, any medication, which, based on his/her assessment and professional judgment, has the potential to be harmful, dangerous, or inappropriate. In these cases, the school nurse shall notify the parent/guardian and licensed prescriber and the reason for the refusal explained. Under Wis. State 118.29(2)(a)(3), anyone with the authority to administer a non-prescription or prescription drug to a student, excluding nurses, is immune from civil liability unless the act or omission constitutes a high degree of negligence.

Consent form on second page

Sheboygan County Medication Authorization Form

Note: each medication requires a separate form

Parent completes this section:

Student _____ Birth date _____
School _____ Grade _____ Teacher/HR _____
Medication _____ Dose _____
Route/Mode of Administration _____ Frequency _____ Duration _____
(not to exceed current school year)
Times to be given _____ Start Date _____ Stop Date _____
Potential Adverse Reactions _____
If PRN (as needed) state conditions under which school personnel should administer medication
(i.e. headache, fever, pain, cough etc.) _____
Student **MAY** or **MAY NOT** carry and/or self-administer medications at school.

I hereby give permission for personnel designated by the principal or school nurse to give this medication to my child according to the directions stated. I also authorize school personnel designated in medication administration to contact my child's practitioner or me if there is a question regarding medication administration. I agree to notify the school when the drug is to be discontinued and/or the dosage or time is changed. I understand that if the medication is resumed, a new medication authorization form is required. I understand that any unused medication will be properly disposed of within 10 days if not claimed after discontinuation of the medication. No medication will be sent home with students. I agree to hold the School District, its employees and agents, excluding health care professionals, who are acting within the scope of their duties, harmless in any and all claims arising from the administration of this medication at school.

X _____ Home Phone _____
(Parent or Guardian Signature)
Date _____ Work Phone _____

Physician completes if medication is prescribed:

I acknowledge by my signature on this document that I will assist and advise designated school personnel with regard to the administration of the medication described below, which includes accepting direct communication. I further acknowledge that all instructions should be stated in language of the lay person. I further understand that if the student is allowed to self-administer medication that proper instruction has been given.

Diagnosis/Reason for Medication _____
Medication _____ Dose _____
Route/Mode of Administration _____ Frequency _____ Duration _____
(not to exceed current school year)
Times to be given _____ Start Date _____ Stop Date _____
Special Instructions for Administration _____
Potential Adverse Reactions _____

(If noted, school personnel should contact parent/guardian/or physician)

Request that school nurse see student in follow up for _____
Student **MAY** or **MAY NOT** carry and/or self-administer medications at school.

Practitioner Signature

Phone Number

Practitioner Name

Practitioner Address

Oostburg School District Fax: (920) 564-6138