Little Chute Area School District Request for Giving Medicine at School

Date: _____ Print Form

Student Name: _____ Date of Birth: _____ Home Room: _____ Grade: _____

Physician's Name: _____ Physician's Address: _____ Physician's Phone: _____

Note: All medication)(both prescription and over the counter) is to be furnished by parent and is to be in on original container. If a prescription medication, ask the pharmacist to divide the medication into two completely labeled containers, providing one for home and one for school

Medications to be given DAILY:

Medication/Dosage	Route	Time of Day	Start Date	Stop Date	Possible Side Effects	Reason for Medication

Direct contact should be made with the physician should the student receiving the medication develop any of the following conditions or reactions to the medication: (if none, so state)

Medications to be given AS NEEDED:

Medication/Dosage	Route	Time of Day	Start Date	Stop Date	Possible Side Effects	Reason for Medication

As a part of the Wisconsin Statute Chapter 118.29, school districts are required to have permission from a medical provider to administrator medications at school. As part of the authorization form, school district employees may contact the medical provider and parent with questions regarding the medication administration including clarification regarding dosage, side effects or indication of the medication(s) listed above. As the parent or guardian of the above mentioned student, I will keep the school district aware of any changes in medication(s) or health concerns for any child.

I hereby give permission to designated school personnel to give medication to my child during the school day, including when away from school property on official school business, according to the written instructions of the doctor as shown on this given form. I hereby give permission to designated school personnel to notify other appropriate school personnel and classroom teachers of medication administration and possible adverse effects of the medication. I further agree to hold the Little Chute Area School District, and the LCASD employee(s) who is (are) administering the medication harmless in any claims arising from the administration of this medication at school.

Date _____ Signature of Parent/Guardian _____

Date _____ Signature of Principal _____

Date _____ Signature of Parent/Guardian _____

Date _____ Signature of Physician-MUST have for prescription medication

Date _____ Signature of Parent/Guardian _____