Little Chute Area School District

HEALTH SERVICES

ADMINISTRATION OF MEDICATION CONSENT

Note: Return the completed form to the main office.

One form for each medication given at school.

New forms required for changes in medication, dosage or time

All medication administered by LCASD staff are only available to students during school hours (8:00AM-3:00PM)

Student's Name:_____ Birthdate:_____/_____/_____

School:_____ Grade/Room_____ Teacher _____

Medication Name/Strength:_____☐ Prescribed* ☐Non-Prescribed

Dosage:_____ How Given: _____ Time to be Given:_____

(in mg, ml, etc.)

Dates Effective (check one): ☐School Year _____ OR ☐ Specific Dates: _____ to _____

Medication Expiration Date, if listed on medication:_____.

Expired medication cannot be administered at school. Please make every effort to provide medication that doesn't expire during the school year.

Reason for Medication/Diagnosis:_____

If "as needed," list conditions under which medication should be given:_____

Possible side effects:_____

***Prescribing Practitioner authorization is REQUIRED for all medications that are: prescription or in dosages that exceed package recommendations.**

***Prescribing Practitioner's Name:_____ Phone:_____ Fax: _____**

***Prescribing Practitioner's Signature:_____**

I hereby give my permission to school personnel to give this medication to my child according to the directions stated above and to contact the child's practitioner if necessary. I further agree to hold the Little Chute Area School District and above person harmless in any and all claims arising from the administration of this medication at school.

As a part of the Wisconsin Chapter 118.29, school districts are required to have permission from a medical provider to administer 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 agree to allow my child to transport the medication(filled or empty) to and from school for the purpose of maintaining medication needed at school for administration and bringing home medication at the end of the school year. Controlled substances may not be transported by students. ☐ YES ☐ NO

Parent/Guardian Signature:_____ Date: _____

Telephone Number:_____ Work Number: _____

Principal's Signature:_____ Date: _____

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