Little Chute Area School District Consent for Self Administration of Medication 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.

Self- administration provisions are intended primarily for high school students only with the exception of controlled substance medications and inhalers. Any misuse of the medication by a student, including selling or giving away the medication, that violates LCASD policies will result in revocation of the self-administration privileges and may result in a referral to law enforcement officials. Parents will be notified of any observed violation of the above guidelines. I am aware that school personnel will not supervise the medication administration or have responsibility in the process. I agree to hold the LCASD harmless in any or all claims arising from the self-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