

# Little Chute Area School District

## HEALTH SERVICES

### AUTHORIZATION FOR SELF-ADMINISTRATION OF MEDICATIONS IN THE SCHOOL SETTING

*Note: Return the completed form to the main office.*

*One form for each medication given at school.*

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: \_\_\_\_\_

Reason for Medication/Diagnosis: \_\_\_\_\_

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

Possible side effects: \_\_\_\_\_

**FOR COMPLETION BY PARENT/GUARDIAN** (Required for all prescription and non-prescription medication)

Is the child authorized to carry and self-administer medication?  YES  NO

As the parent/guardian of the above named student, I ask that my child be permitted to self-medicate as authorized by myself and the prescribing practitioner. Authorization is hereby granted to release this information to appropriate school personnel and classroom teachers and to contact the child's practitioner if necessary.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**\*FOR COMPLETION PRESCRIBING PRACTITIONER** (REQUIRED for all prescription medications or medication dosages exceeding typical recommendation. Per LCASD medication policy, non FDA-approved medication cannot be administered).

Prescribing Practitioner's Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Is the child knowledgeable about his or her medication?  YES  NO

Has the child demonstrated the proper technique in administering medication?  YES  NO

If needed, how soon can administration of medication be repeated? \_\_\_\_\_

I have instructed \_\_\_\_\_ in the proper way to use his/her medication. It is my professional opinion that he/she should be allowed to carry and use this medication by him/herself.

It is my professional option that \_\_\_\_\_ should not carry and administer his/her medication by him/herself.

\*Prescribing Practitioner's Signature: \_\_\_\_\_

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.

Self-administration provisions are intended primarily for high school students only with the exception of controlled substance medication, inhaler, and epi pens. Any misuse of the medication by a student, including selling or giving away the medication 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 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.

Principal's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Created 6/17