Little Chute Area School District
Health Services
MEDICATION ADMINISTRATION CONSENT

Samantha Busko, MSN, RN, School Nurse 920-788-7600
Elementary Fax: 920-788-7847 AND IM/MS/HS Fax: 920-788-7841

STUDENT & PHYSICIAN INFORMATION

STUDENTS NAME:	**DOB**:	**GRADE:**
SCHOOL ATTENDING:		**BUS STUDENT**: *YES* *NO*
PHYSICIANS NAME:		**PHONE NUMBER:**

As a part of the Wisconsin Statute 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 my child.

DAILY MEDICATION

MEDICATION/ DOSAGE	*ROUTE*	*TIME*	*START DATE*	*STOP DATE*	*POSSIBLE SIDE EFFECTS*	*REASONS FOR MEDICATION*	*ADMINISTRATION ROUTE:*	
							Given By Staff	*Self-Administer**

AS NEEDED MEDICATION

MEDICATION/ DOSAGE	*ROUTE*	*TIME*	*START DATE*	*STOP DATE*	*POSSIBLE SIDE EFFECTS*	*REASONS FOR MEDICATION*	*ADMINISTRATION ROUTE:*	
							Given By Staff	*Self-Administer**

MEDICATION ADMINISTRATION & AUTHORIZATION

DISCLAIMER FOR ADMINISTRATION OF MEDICATION BY STAFF (LCASD)

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 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 or all claims arising from the administration of this medication at school.

DISCLAIMER FOR SELF-CARRYING OF MEDICATION (SELF-ADMINISTER)*

Students Grade 7-12 OR students with emergency medications (ex. Inhaler, epi-pens, Auvi-Q and/or seizure medications) who are deemed responsible will be able to self-carry and self-administer their medications. By indicating self-administer, I agree that this student is properly trained to use and administer their medications. 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. 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.

***Note**: If self-administer is selected and the student is under 7th grade, the medication is not deemed an emergency medication, or the student is deemed as not responsible to self-administer appropriately, the medication will only be administered by staff and housed in the health office.*

PARENT/GUARDIAN MEDICATION CONSENT

I hereby give permission to designated trained school personnel to give medications 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 form. I also hereby agree to give my permission to the school nurse and/or school personnel to contact the child's physician if needed. I hereby give permission to designated school personnel to notify other appropriate school personnel and classroom teachers of medication(s) administration and possible adverse effects of the medication. I further agree to hold the Little Chute Area School District and LCASD employee(s) who is (are) administering the medication harmless in any or all claims arising from the administration of this medication at school. I agree to notify the school at the termination of this request or when any changes in the above orders are necessary. I understand, as the parent/guardian, I am responsible to assure that backup rescue medication is available to my child after school hours and traveling to/from and during school-sponsored events. Students' health information is shared via emails, copies of health plans and/or staff meetings with grade level teachers, coaches, bus companies, office staff and other pertinent LCASD staff.

By signing below you agree you have reviewed this health plan for your child and that the health plan is correct and/or you have made the appropriate changes on this form to make the plan correct.

EMERGENCY CONTACT:	**RELATIONSHIP TO STUDENT:**
(H) PHONE:	**(C) PHONE:**
PARENT/GUARDIAN SIGNATURE:	**DATE:**
THE BELOW SECTION IS ONLY REQUIRED FOR <u>PRESCRIPTION MEDICATIONS</u>	
PHYSICIANS NAME:	**PHONE:**
PHYSICIAN SIGNATURE:	**DATE:**

Principal's Initials: _____ Date: _____

ADMINISTRATION OF MEDICATIONS TO STUDENTS

MEDICATION SHOULD BE ADMINISTERED TO STUDENTS BY THEIR PARENTS/GUARDIANS AT HOME WHENEVER POSSIBLE.
All health-related policies, information and forms can be found on the District Website.

Note: *All medication (both prescription and over-the-counter) is to be furnished by the parent and must be in the 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.*

PRESCRIPTION MEDICATIONS:

1. Medication to be given in school is required to have a Medication Administration Consent form completed by a licensed prescriber, at the beginning of each school year. Medication authorizations will be valid for the current school year and must be renewed annually. Any change in a medication type, route, dosage, frequency or time requires a new written medication order. Only the school nurse shall receive a telephone order for any change in medication. ***Please note****: No medications will be given without the proper physician order and parent consent on file.*

2. In accordance with standard medical practice, a medication order from a licensed prescriber shall contain: a. name of the student; b. student's date of birth; c. name and signature of the licensed prescriber, and business/emergency telephone numbers; d. name of the prescription drug; e. route, dosage, frequency and time of medication administration; f. the effective dates; (if you would like consent to apply to summer school, please have physician extend "end" date through completion of summer learning sessions (e.g. 8-30-13). g. diagnosis; h. specific directions for administration in a legible format.

3. Additional information shall be obtained from the licensed prescriber, if appropriate: a. any special side effects, contraindications and adverse reactions to be observed; b. any other medications being taken by the student; c. an order to discontinue a prescribed medication.

4. Students will take medication at a designated time supervised by authorized personnel.

5. Students at LCASD grades 7-12 may carry and self-administer medications as long as it is not a controlled substance. Written approval, signed by the Parent and physician, must be in place for the student to self-administer any prescription medication.

NON-PRESCRIPTION MEDICATIONS:

Parents must complete and turn in to the office a Request for Giving Medication at School form.
Students at LCASD may carry and self-administer an over-the-counter medication with the Request for Medication Administrations form. Students must carry medication and a copy of this form at all times. Originals of this form must be turned into the office.

NON-PRESCRIPTION STOCK MEDICATIONS:

A limited amount of stock medications are kept in the health room at LCASD for grades 7-12. These include Acetaminophen, Ibuprofen, Tums and Benadryl. Parents must complete and turn in to the office a Permission for Administering Stock Medications at School form.