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