School District of Sheboygan Falls – Telephone and Fax Numbers

Sheboygan Falls Elementary	Phone 920-467-7820	Fax 920-467-7824
Sheboygan Falls Middle	Phone 920-467-7880	Fax 920-467-7885
Sheboygan Falls High	Phone 920-467-7890	Fax 920-467-7825

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SHEBOYGAN COUNTY STUDENT MEDICATION AUTHORIZATION FORM

Dear Parent or Guardian:

Medications should be administered to students by their parents/guardians at home whenever possible. In the event this is not possible, proper written consent must be given for designated school personnel to administer medication. **Each medication requires a separate authorization form.**

For Nonprescription Medications:
Parent/Guardian written authorization is required.

For Prescription Medications:
Parent/Guardian written authorization and Practitioner written authorization is required.

No medication will be administered by school personnel or its agents until the consent forms are completed and on file with the school. Medication authorization and administration forms will be kept and stored confidentially as required under Wis. Stat. 118.29(4).

All medication must be in the *original container* labeled with the student's name, correct dosage, time and quantity to be given. All prescription medication must be in the *original container* labeled from the pharmacy. All medication will be kept in a securely locked cabinet or storage area only accessible to those who have been given the authority to administer medications to students.

Parents are responsible for bringing medication to school and picking up unused medication within 10 days after the medication is discontinued. Students are not allowed to transport their medication from school. School personnel who administer medications to students will have been provided orientation and training. By law, school personnel may not cut tablets. If your child needs to receive half a tablet, have this done at home or by the pharmacy filling the prescription. Current school policy does not allow non-FDA approved drugs (herbal medication) to be administered at school unless physician approval is obtained in advance.

Students who self-administer medication must have a medication authorization form on file at school. It is recommended that students carry no more than one-week medication supply.

In accordance with the standards of nursing practice, the school nurse may refuse to administer or allow to be administered any medication, which, based on her/his assessment and professional judgement, has the potential to be harmful, dangerous, or inappropriate. In these cases, the school nurse shall notify the parent/guardian and licensed prescriber and the reason for the refusal explained. Under Wis. State 118.29(2)(a)(3), anyone with the authority to administer a non-prescription or prescription drug to a student, excluding nurses, is immune from civil liability unless the act or omission constitutes a high degree of negligence.

Consent form on reverse side
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Sheboygan County Medication Authorization Form

Note: Each Medication requires a separate form

Parent completes this section:

Student ____________________ Birthdate ____________

School ____________________ Grade ______ Teacher/HR ____________

Medication ____________________ Dose ____________

Route/Mode of Administration ____________ Frequency ____________ Duration ____________
(Not to exceed current school year)

Times to be given ____________ Start Date ____________ Stop Date ____________

Potential Adverse Reactions____________________

If PRN (as needed), state conditions under which school personnel should administer medication
i.e. Headache, Fever, Pain, Cough, etc…____________________

Student ***may***______ ***may not*** _______ carry and/or self-administer medications at school.

I hereby give permission for personnel designated by the principal or school nurse to give this medication to my child according to the directions stated. I also authorize school personnel designated in medication administration to contact my child's practitioner or me if there is a question regarding medication administration. I agree to notify the school when the drug is to be discontinued and/or the dosage or time changed. I understand that if the medication is resumed, a new medication authorization form is required. I understand that any unused medication will be properly disposed of within 10 days if not claimed after discontinuation of the medication. No medication will be sent home with students. I agree to hold the School District, its employees and agents, excluding health care professionals, who are acting within the scope of their duties, harmless in any and all claims arising from the administration of this medication at school.

X____________________ Home phone ____________________
(Parent or Guardian Signature)

Date ____________ Work phone ____________________

Physician Completes if Medication is Prescribed:

I acknowledge by my signature on this document that I will assist and advise designated school personnel with regard to the administration of medication described below, which includes accepting direct communication. I further acknowledge that all instructions should be stated in language of the lay person. I further understand that if the student is allowed to self-administer medication that proper instruction has been given.

Diagnosis/Reason for Medication ____________________

Medication ____________________ Dose ____________

Route/Mode of Administration ____________ Frequency ____________ Duration ____________
(Not to exceed current school year)

Times to be given ____________ Start Date ____________ Stop Date ____________

Special Instructions for Administration ____________________

Potential Adverse Reactions ____________________
(If noted, school personnel should contact parent/guardian/or physician)

Request that school nurse see student in follow-up for:____________________

Student ***may*** ______ or ***may not*** ______ carry and/or self-administer medications at school.

____________________ ____________________
(Practitioner Signature) (Phone Number)

____________________ ____________________
(Practitioner Name) (Date) (Practitioner Address)