KASD MEDICATION CONSENT
REQUEST FOR GIVING MEDICATION
2017-2018

Request for Giving Medication **form is acceptable for all forms of medication except those given for** ***asthma, bee sting allergy, diabetes, food allergy and seizures. These forms are available in your student's school office or online at www.kimberly.k12.wi.us under Health Services.***

Student:	**Date of Birth:**	**Home Room:**	**Grade:**
Physicians Name:		**Physicians Phone Number:**	

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

DAILY Medications to be given:

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): _____

AS NEEDED Medications to be given:

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 administer medications. 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.

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 Kimberly Area School District, and the KASD employee(s) who is (are) administering the medication harmless in any or all claims arising from the administration of this medication at school.

Date	Signature of Parent/Guardian	Principal Initials
Date	Signature of Physician MUST have for prescription medication	Physician's Address

ADMINISTRATION OF MEDICATIONS TO STUDENTS
Medication should be administered to students by their parents/guardians at home whenever possible.

Prescription Medications:

1. Medication to be given in school **MUST** have a ***Request for Giving Medication at School 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. 8-30-17).*
    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 grades K – 12 will take medication at a designated time supervised by authorized personnel.
5. Students in high school (grades 9-12) 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:

1. Parent must complete and turn in to the office a ***Request for Giving Medication form***.
2. Students in grades 9-12 may carry or self-administer an over the counter medication with the ***KASD Medication Consent for Kimberly High School Consent*** form on file.

All medications (both prescription and nonprescription) are to be furnished by the parent/guardian and are to be in an original container with the students name on it. The label on a prescription bottle must include the most up-to-date medication and dosage order.

Non-Prescription Stock Medications:

A limited amount of stock medications are kept in the health room at JRG and KHS. These include Acetaminophen, Ibuprofen and Diphenhydramine.

1. Parents must complete and turn in to the office a ***Permission for Administering Stock Medications*** form.
2. If a parent wishes for their child to receive medication from this supply, all of the criteria under ***Non-Prescription Medications*** must be met.

All health related policies, information and forms can be found on the District web site @ www.kimberly.k12.wi.us. See health services under Department heading. You may also call the district nurse at 788-7900. District confidential FAX 920-788-7919.

10/2015