Hustisford School District Authorization to Administer Medication

High School Ph: 920-349-3261 Elementary School Ph: 920-349-3228
HIgh School Fax: 920-349-8495 Elementary School Fax: 920-349-3530

TO BE COMPLETED BY THE PARENT/GUARDIAN:

Name of Student_____ **Date of Birth:**_____ **Grade:** _____

I give permission for my son/daughter to receive the prescription/FDA approved over the counter medication during school hours and during school sponsored activities/field trips that occur after hours. I will be responsible for:

1. Delivery of medication in a pharmacy labeled/original manufacturer's container to the school office
2. Maintaining a sufficient supply of medication
3. Keeping school personnel informed of changes in the medication (dosage,time)
4. Obtaining a new form from the prescribing physician for any changes in this medication

I hereby release the board of Education and its agents and employees from any and all liability that may result from my child taking the prescribed medication.I understand the above information may be shared with necessary school personnel. The physician order/parental consent above shall remain in effect through the end of the current school year unless discontinued/ changed by the provider or parent/guardian withdraws the request in writing. In addition, I give my permission for school health staff to discuss this medication with the prescribing provider if needed. My signature indicates I have read and understand the above information.

Name of Medication: _____ **Dose:** _____ **Time:**_____

Conditions to be given for: _____

Prescription medication only:

Prescribing Provider: _____ **Provider Ph. Number:** _____

For Metered Dose inhalers and Epi-pens only:My student has received instruction and demonstrated competency in the use of the above medication. He/She may carry & self-administer: YES/NO

AT THE END OF THE SCHOOL YEAR, PLEASE (check one):

Contact me to pick up remaining medication	Dispose of remaining medication	Send remaining medication home with my student

Parent Signature_____ **Date**_____

Reviewed 4/2023

TO BE COMPLETED BY THE PROVIDER:

- The above medication is to be administered in accordance with the written instructions/agreements
- I understand non-medically trained school personnel may give medication

Physician Signature_____ **Date:** _____

As part of the Wisconsin Statute Chapter 118.29, Administration of Drugs to Pupils and Emergency Care, school districts are required to have permission from a medical provider and parent to administer medications at school. I authorize school district employees to contact myself with questions regarding the medication administration including clarification regarding dosage, side effects or indication of the medications listed above.