# PLYMOUTH JOINT SCHOOL DISTRICT 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 condition under which school personnel should administer medication (i.e. Headache, fever, pain, cough, etc…)_____

Physician Name _____

*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. 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)

Work Phone _____

Date: _____

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**Physician completes this section for prescription medication:**

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 layperson. I further understand that if a 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* _____*may not* _____ carry and/or self-administer emergency meds ( i.e. Epi-pen, Glucagon, Inhalers) at school.

_____ _____
(Practitioner signature) (Phone number)

_____ _____ _____
(Practitioner name) (Date) (Practitioner address)

PLYMOUTH JOINT SCHOOL DISTRICT
MEDICATION AUTHORIZATION FORM

Dear Parent/Guardian,

If a student must take medication he/she should do this at home whenever possible. In the event a student must take medication at school, proper written consent must be given to designated school personnel to administer the medication.

**Each medication requires a separate authorization form.**

**For Non-prescription medications –** Parent/Guardian written authorization is required.

**For Prescription medication -** Parent/Guardian AND physician/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). No medications, other than those designated as emergency, may be carried/self-administered at school unless the student's physician, parent and school nurse are in agreement. Students who self-administer medication must have a medication authorization form on file at school.

All medication must be in the original container, non-prescription and prescription. All prescription medication must have a pharmacy label including the student's name, correct dosage, time and quantity to be given. 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 medication 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.

School personnel who administer medication 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 cut the tablets at home or have the pills cut at the pharmacy filling the prescription.

Current school policy does not allow non- FDA approved drugs (herbal and dietary supplements) to be administered at school.

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 judgment, has the potential to be harmful, dangerous or inappropriate. In these cases, the school nurse shall notify the parent/guardian and licensed prescriber and explain the reason for refusal. Under Wis. Stat. 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**