LUCK SCHOOL DISTRICT

810 7th Street South, Luck, WI 54853   Phone: 715-472-2152   Fax: 715-472-2159

MEDICATION AUTHORIZATION FORM

Dear Parent/Guardian,

If a student must take medication, he/she should do this at home whenever possible. Per the Luck School District policy # 5330: In the event a student must take medication at school, proper written consent must be given to school personnel to administer the medication.

Each medication requires a separate authorization form and must be renewed each year.

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

For prescription medication – Parent/Guardian AND medical provider written authorization is required.

No medication will be administered by school personnel until the consent forms are completed and on file with the school. Medication authorization and administration forms will be kept and stored confidentially. No medications, other than those designated as emergency, may be carried/self-administered at school. 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 pharmacy label. Pharmacy will provide extra container for school if medication must be taken during the day. If the prescription requires a child to receive half tablets, cut the tablets at home or have the pills cut at the pharmacy filling the prescription. Pills will not be cut at school. 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 completed WI DPI Medication Training specific to the medication being administered.

Current school policy does not allow non-FDA approved drugs (herbal and dietary supplements) to be administered at school without written instructions from a licensed practitioner. No CBD products will be permitted for use at school.

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

LUCK SCHOOL DISTRICT MEDICATION AUTHORIZATION FORM

Note: Each medication requires a separate form

Parent completes this section for ALL medication:

Student ____ Birthdate _______________________________

Teacher ____ Grade ___________________

Medication ____ Dose ________________________________

Route/Mode of administration ______________________________ Frequency ___________________ Duration _________________

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 appropriately trained personnel 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 if 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 if not claimed within 10 days after discontinuation of the medication. I agree to hold the School District, its employees and agents, excluding healthcare 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____ Date ___________________

(Parent or Guardian Signature)

Home phone ______________________________________ Work phone _______________________________________

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 ________________________

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) _________________________

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) (Clinic name)