School District of Kettle Moraine

Medication Authorization

This form must be completed if your child requires any medication at school.

STUDENT				
Student Legal Name *(as it appears on birth record or other legal document)*				
First	*Last*	*Middle*	*Suffix*	*Nickname*
Gender	*Birth Date*	*Age*	*Grade*	

FOR COMPLETION BY PHYSICIAN			
MEDICATION	**DOSE**	**ROUTE**	**TIME/FREQUENCY**

REASON FOR MEDICATION:

For Asthma inhalers Student may carry inhaler in school Yes ____ No _____

PHYSICIAN SIGNATURE DATE

Physician Name/Practice____
Address____
Phone_____________________________________ Fax____

- **Wisconsin Statute 118.291 and School District Policy require pupils to have written authorization by a physician and parent/guardian on file with the school administration for ALL prescription medications including EpiPens and inhalers.**
- **Short term (< 5 days) non-prescription drug products may be administered with only a <u>parent/guardian's</u> written authorization if the school nurse determines: The drug product and the dosage is the recommended therapeutic dose and is being used as indicated on the package labeling AND the parents/guardians have supplied the drug product in the original manufacturer's package and have agreed to discontinue the drug product if symptoms worsen or adverse reactions are evident. Extended use of the non-prescription drug product or dosage that exceeds the recommended therapeutic dose will require written approval of the child's health care practitioner.**
- **<u>Additional authorization may be required for out of state / country or overnight field trips.</u>**

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FOR COMPLETION BY PARENT

As parent of the above named student I give permission for school staff to supervise the administration of the medication authorized by my physician. I agree to notify the school directly at the termination of this request, or when any changes in the above order are necessary. I authorize the school nurse to contact the physician directly for clarification of this medical order or to report any adverse reactions or side effects. I understand that it may be necessary to share the information on this form with other school staff to ensure proper administration of this medication. This information may also be shared with emergency medical staff in the event of a health or safety emergency necessitating transport to a medical facility.

______________________________________ PARENT SIGNATURE	______________________ DATE

School Nurse Signature: ____ Date: _________