# IMPORTANT MEDICATION NOTICE

**If your child needs to take medication on a regular basis during the school day, this form must be completed and signed by the authorizing physician, and also signed by the parent. Please note that no prescription medication can be administered to your child at school until the school nurse has received this signed authorization form.**

**If your child needs to take medication temporarily due to an illness or condition, please note that the medication must be in its original container, and accompanied by a note from the parent. The medicine must be kept in the office to be administered at the time appointed on the container or note from the parent. Students are not allowed to keep medications in their locker. See the Student Handbook for further details.**

**Thank you for your cooperation.**

# WEST MONONA COMMUNITY SCHOOL DISTRICT
# AUTHORIZATION/PERMISSION FOR ADMINISTRATION OF MEDICATION/PROCEDURE

Code No. 507.2E2

Student's Name _____ Birthdate _____ Today's Date _____

Medications and health care procedures required during school, which cannot be managed at home, shall be administered when the following are on file at the school:

- Physician's signed, dated authorization including the medication/procedure, reason receiving, dosage, route of administration, time given at school, symptoms and side effects.
- Parent/Guardian signed, dated authorization/permission to administer the medication/procedure.
- Medication/equipment delivered to school by the parent in the original packaging.
- A prescription label must be attached to the medication container(s).
- Authorization orders must match the prescription label on the medication container(s).
- Annual renewal of authorization/permission and immediate notification, in writing, of changes.
- Medication/procedure will be kept in a secured area and shall be administered by qualified staff and a record maintained.

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## PHYSICIAN AUTHORIZATION

The above named student is under my medical supervision. I have prescribed the following:

Medication/Procedure _____ Dosage _____ Route _____

Time Given at School _____ Discontinue Date/Re-evaluate Date/Follow-up _____

Medical Diagnosis/Reason(s) for Medication or Procedure _____

Anticipated Reactions/Possible Side Effects _____

Physician's Signature _____ Date _____

Physician's Address _____ Emergency Phone _____

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## PARENT AUTHORIZATION/PERMISSION

I request the above student be given the medication/procedure at school and school activities by qualified staff, according to the prescription or nonprescription instructions and a record maintained. The student has experienced no previous side effects from the medication. I further agree that school personnel may contact the prescriber as needed and that medication information may be shared with school personnel who need to know.

I understand the law provides that there shall be no liability for civil damages as a result of the administration of medication where the person administering the medication acts as an ordinarily reasonably prudent person would under the same or similar circumstances. I agree to provide safe delivery of medication and equipment to and from school and to pick up remaining medication and equipment.

I grant my permission to share health information as stated above. Yes_____ No_____

Parent's Signature _____ Date _____

Parent's Address _____ Home Phone _____

Additional Information _____ Work/Cell Phone _____

(Rev 8/06)