Elkhorn Area School District Permission for School Administration of Prescription Medication

***No medication shall be given unless this form is completed by the student's parent/guardian AND* physician or authorized provider.**

Students are NOT PERMITTED to have any type of medication in their possession with the exception of those who require a rescue inhaler, an Epipen or diabetic care supplies as stated below. Medications should be administered by a parent or guardian before or after school hours, when possible. **School Year:** __________/___________ (Form is valid for only this school year)

Student Name:_______________________________________**Student age:**_____**Date of Birth:**___/____/________

Name of School: _______________________________**Grade:** _________ **Homeroom/Classroom:** ______________

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PROVIDER

Name of Medication: (ONE medication per form)	Dosage:	□ As Needed □ As Requested □ As Scheduled
Reason for Medication:	Route:	

Form of medication/treatment:
□ Tablet/capsule □ Liquid □ Inhaler □ Injection □ Nebulizer □ Other ______________________________

Instructions (Schedule): ____
Start: □ Date form received □ Other, as specified: ____
Stop: □ End of school year □ Other date/duration:____
□ **For episodic/emergency events only**:____

Restrictions and/or important side effects: □ No restrictions
□ Yes. Please describe: ____

Special storage requirements: □ None □ Refrigerate Other: ____________________________________

♦♦♦For Self-Administration ONLY♦♦♦For Self-Administration ONLY♦♦♦For Self-Administration ONLY♦♦♦

To be completed for asthmatic, diabetic or severe allergic reaction (anaphylaxis) ONLY.

Pursuant to Wis. Stat 118.29 to Wis. Stat 118.2925 the Elkhorn Area School District permits a student to possess and self-administer asthma, anaphylaxis, or diabetes-related medication at school and at school-related functions upon completion of the following information by the parent/guardian and the student's physician and waiver of liability by the parent/guardian. **This student has been instructed on self-administration of this medication by prescribing health care provider and parent and is developmentally able to carry out self-administration of this medication:**

□ No, should not self-administer □ Supervision required □ Supervision not required

This student may carry this medication: □ No □ Yes

Prescribing Health Care Provider's Signature **Date**		Stamp of Health Care Provider's Name & Address
Office Phone Number:	Office Fax Number:	

TO BE COMPLETED BY PARENT / GUARDIAN

I give permission for (name of child)___________________________________to receive the above stated medication at school according to standard school policy. I release the Elkhorn Area School Board and its employees from any claims or liability connected with its reliance on this permission. I give permission for the health care provider named above to provide information about this medication and my child's health to the school nurse or school administrator.
(As required by law, Parent/guardians to bring the medication in its original pharmacy container.)

Signature: ____________________________________**Relationship:** __________________**Date:** ___________

Emergency phone/email:____