EAST TROY COMMUNITY SCHOOL DISTRICT

Committed to the Growth & Success of Each Student, Each Year

AUTHORIZATION FOR ADMINISTRATION OF PRESCRIPTION MEDICATION

SCHOOL INFORMATION

◯ Little Prairie Primary School	◯ Prairie View Elementary School	◯ East Troy Middle School	◯ East Troy High School
2109 Townline Rd, East Troy	2131 Townline Rd, East Troy	3143 Graydon Ave, East Troy	3128 Graydon Ave, East Troy
P: 262-642-6730, F: 262-642-2724	P: 262-642-6720, F: 262-642-6788	P: 262-642-6740, F: 262-642-6743	P: 262-642-6760, F: 262-642-6776

STUDENT INFORMATION

Student's Name:_____ Date of Birth:_____ Gr:_____ Sex: ◯ M ◯ F

Parent's Name:_____ Home #:_____ Cell #:_____

Physician's Name:_____ Phone #:_____ Fax #:_____

Physician's Address:_____ City:_____ St:_____ Zip:_____

PRESCRIPTION MEDICATION INFORMATION - TO BE COMPLETED BY THE PHYSICIAN

According to the State of Wisconsin Medical Examining Board and the East Troy School District's "School Medication Policy", it is required to complete this form before school personnel may dispense or administer medication.

Medication Name:_____ Dose:_____ Frequency:_____

Route: ☐ Oral ☐ Inhalation ☐ Eye/Ear/Nose Drops ☐ Topical ☐ Other:_____

Time of day to be given:_____ ◯ AM ◯ PM Recommended Duration:_____

If PRN, describe indication(s):_____ If PRN, how often can it be repeated:_____

Side Effects (expected or predictable):_____

Adverse Effects (require notification of parent/physician):_____

Special Instructions:_____

Self-Administration of Medication by Student: It is strongly recommended that all medication be administered by designated school staff and be kept secure in the school office. No controlled substances may be kept or self-administered by the student. Students (grade 6-12) may self-administer medication provided parent and physician authorization is granted.

☐ **This student may carry and self-administer this medication.**

I am willing to accept direct communication from the person dispensing or administering the medication.

Physician's Signature:_____ Date:_____

If phone order, taken by:_____ Date:_____

Phone orders expire in 10 days, if not signed by a physician.

PARENT/GUARDIAN SIGNATURE

I request and authorize that my son/daughter be assisted in taking the medication described above at school by designated school staff. I hereby release the Board of Education and its agents and employees from any and all liability that may result from my child taking the prescribed medication. I consent to any communication between the prescribing physician (or health care practitioner) and the school regarding this medication and related health information.

☐ **If applicable, I agree with the physician's statement above regarding self-administration.**

Parent/Guardian's Signature:_____ Date:_____