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SCHOOL DISTRICT OF RANDOM LAKE

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Random Lake, Wisconsin 53075

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SAVE AND FILL OUT THESE FORMS IF YOUR SON OR DAUGHTER NEEDS TO TAKE MEDICINE AT SCHOOL

The Random Lake School Board adopted a new medication policy on November 16, 1987. Before school personnel can give medicine to your son or daughter, a parent needs to:

FOR NON-PRESCRIPTION MEDICINE

1. Fill out the first part of the form, labeled "PARENT"
2. Send the medicine to school in the original container with the name of the student, name and dose of the medicine, the time and quantity for the student, and the duration.

FOR PRESCRIPTION MEDICINE

1. Fill out the entire form. The doctor needs to fill out the second part.
2. Send the medication to school in the original pharmacy-labeled container.

Attached are copies of the form. More forms are available in the school office. This policy protects the safety of your son or daughter, which is in line with state law 334. Medications cannot be given in school without completed forms.

Prescription drug form by

RANDOM LAKE SCHOOL DISTRICT

Permission to Administer Medication at School

Student Name _____ **D.O.B.** _____ **Grade** _____

Parent Name _____ **Home Phone** _____ **Work/Cellphone** _____

The Random Lake School District is **required** to have written parental/guardian consent for **all** medication administered at school. Prescription medication requires physician directions and signature. This order is valid only for the school year 20____- 20____ including the summer session.

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PARENT

I request that my child receive the following medication administered by appropriately trained school personnel as authorized by me (and my physician if prescription). Specific questions/concerns may be communicated to the physician by a professional staff member serving the school.

Drug Name	Dosage	Time	Route	Duration

I further agree to hold the Random Lake School District and all employees harmless in any and all claims arising from the administration of this medication at school. I agree to notify the school in writing at the termination of this request or of any change in medication.

***It is highly recommended that medication be transported to school by the parent. According to school policy, all prescription medications must be in a properly labeled pharmacy bottle and over the counter medications must be in their original containers.**

_____ _____

Signature of Parent/Guardian **Date**

NOTE: Any change in medication will require a new form. For year-long medications, consent to administer will expire at the end of each school year. ****Parents are required to pick up all medication at school when discontinued or at the end of school year. Medication left 3 weeks after this time will be properly disposed of.

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PHYSICIAN: (for prescription drugs only)

Prescribing Physician _____ **MD Phone** _____ **MD Fax** _____

The following is to be completed by the child's physician prior to administration at school.

Medication	Dosage	Time	Route	Duration of Medication

1. Is this medication a PRN drug? _____YES _____NO
2. Under what conditions or schedule the drug should be given and repeated: _____
   _____
3. Side effects (expected or predicted): _____
4. Purpose of the medication: _____

SELF CARRY/SELF ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION

Self carry/self administration of **emergency** medication may be authorized by the prescriber if approved by the school nurse.

PRESCRIBING PHYSICIAN	SCHOOL NURSE
Prescriber's authorization for self-carry/self-administration of emergency medication (initial): _____ yes _____ no	Approved by School Nurse for self-carry/self-administration of emergency medication (initial): _____ yes _____ no
_____ _____	_____ _____
Signature of Prescribing Physician **Date**	**Reviewed by School Nurse (sign and date)** **Date**

PHYSICIAN'S OFFICE: Please fax completed form to Random Lake School District at (920) 994-4820 Revised 07/25/2013