Form 1a

SHEBOYGAN COUNTY STUDENT MEDICATION AUTHORIZATION FORM

Dear Parent or Guardian:

Medications should be administered to students by their parents/guardians at home whenever possible. In the event this is not possible, proper written consent must be given to designated Kohler Kare personnel to administer medication.

For Nonprescription Medications:

Parent/Guardian written authorization is required.

For Prescription Medications:

Parent/Guardian written authorization and Practitioner written authorization is required.

No medication will be administered by Kohler Kare personnel or its agents until the consent forms are completed and on file with the day care. Medication authorization and administration forms will be kept and stored confidentially as required under Wis. Stat. 118.29(4).

All medication must be in the *original container* labeled with the student's name, dosage, time, and quantity to be given. All prescription medication must be in the *original container* labeled from the pharmacy. All medication will be kept in a securely locked cabinet or storage area only accessible to those who have been given the authority to administer medications to students.

Parents are responsible for bringing medication to Kohler Kare and picking up unused medication within 10 days after the medication is discontinued. Students are not allowed to transport their medication from day care. Kohler Kare personnel who administer medications to students will have been provided orientation and training. By law, day care personnel may not cut tablets. If your child needs to receive half a tablet, have this done at home or by the pharmacy filling the prescription. Current day care policy does not allow non-FDA approved drugs (herbal medication) to be administered at school.

Students who self-administer medication still need to have a medication authorization form on file at day care. It is recommended that students carry no more than one-week medication supply.

Form 1b

Sheboygan County Medication Authorization Form

Note: Each medication requires a separate form

Parent Completes This Section:

Name: _____ Birthdate: _____

School: _____ Grade: _____ Teacher/HR: _____

Medication: _____ Dose: _____

Route/Mode of Administration: _____ Frequency: _____ Duration: _____
(Not to exceed current school year)

Times to be Given: _____ Start Date: _____ Stop Date: _____

Potential Adverse Reactions: _____

If PRN (as needed), state conditions under which school personnel should administer medication *(i.e. headache, fever, pain, cough, etc.)*: _____

Student **may** _____ or **may not** _____ carry and/or self-administer medications at school.

I hereby give permission for personnel designated by Kohler Kare to give this medication to my child according to the directions stated. I also authorize Kohler Kare personnel designated in medication administrated to contact my child's practitioner or me if there is a question regarding medication administration. I agree to notify Kohler Kare when the drug is to be discontinued and/or the dosage or time changed. I understand that if the medication is resumed, a new Medication Authorization Form is required. I understand that any unused medication will be properly disposed of within 10 days if not claimed after discontinuation of the medication. No medication will be sent home with student only parents. I agree to hold Kohler Kare its employees and agents, excluding health care professionals, who are acting within the scope of their duties, harmless in any and all claims arising from the administration of this medication at day care.

X _____ Home Phone: _____
(Parent or Guardian Signature)

Date: _____ Work Phone: _____

Physician Completes if Medication is Prescribed:

I acknowledge by my signature on this document that I will assist and advise designated Kohler Kare personnel with regard to the administration of medication described below, which includes accepting direct communication. I further acknowledge that all instructions should be stated in language of the lay person. I further understand that if the student is allowed to self-administer medication, that proper instruction has been given.

Diagnosis/Reason for Medication: _____

Medication: _____ Dose: _____

Route/Mode of Administration: _____ Frequency: _____ Duration: _____
(Not to exceed current school yr.)

Times to be Given: _____ Start Date: _____ Stop Date: _____

Special Instructions for Administration: _____

Potential Adverse Reactions: _____
(If noted, school personnel should contact parent/guardian/or physician)

Request that school nurse see student in follow-up for: _____

Child **may** _____ or **may not** _____ carry and/or self-administer medications at school.

_____ _____
(Practitioner Signature) (Phone Number)

_____ _____
(Practitioner Name) (Date) (Practitioner Address)