LAKE MILLS SCHOOL DISTRICT
AUTHORIZATION FOR ADMINISTRATION OF
PRESCRIPTION AND NON-PRESCRIPTION MEDICATION

Student's Name_____Physician's Name_____

Birthdate _____ Physician's Address_____

School _____Grade/Teacher_____

Parent/Guardian_____ Physician's Phone _____

Phone _____Physcian's FAX _____

TO THE PHYSICIAN/PARENT: According to the State of WI Medical Examining Board and the Lake Mills School District po5330 Administration of Medication/Emergency Care, it is required to fill out this form before school personnel may dispense or administer medication. Medication must be supplied in the original container or packaging. For safety and liability reason, medication received in any container other than the original will not be acceptable for staff administration. Parent/Guardian: By signing this form, releases the Board of Education, its agents and employees from any and all liability that may result from taking this medication and you agree to provide safe transportation of medication to and from school.

_____

Medication_____Reason for this Medication_____

Amount and time to be given_____

Duration of treatment (start date/stop date)_____

If given on an "as needed" basis, please describe_____

How soon can it be repeated?_____

Side effects and/or special instructions_____

Self-Administration of Medication by Student: It is strongly recommended that all medications be administered by designated school staff and be kept secure in the school office for those students in Pre-K-8. If a student in grades Pre-K-12 needs to carry and self-administer certain emergency medications such as epipen, asthma inhaler, insulin or glucagon, special permission will be granted with the parent and physician authorization.

Please0 specify if student may carry and self-administer this medication (Specify type above):_____YES_____NO

I, the prescribing physician, am willing to accept direct communication from the person dispensing and administering the above medication.

PHYSICIAN'S SIGNATURE_____DATE_____

PARENT/GUARDIAN SIGNATURE _____DATE _____
(Required for Prescription and Non-Prescription medications).