# Winneconne Community School District
## Medication/Treatment Authorization Form

All portions of the Medication/Treatment Authorization Form must be completed before medication can be administered by school district personnel. Incomplete forms may result in the form being returned for full completion.

**Keep in mind:**

- One medication per authorization form;
- All prescription medication requires BOTH a practitioner signature and parent/guardian signature;
- All over the counter medication requires ONLY parent/guardian signature, *unless* outside of the recommendations of manufacturer, in which case a practitioner signature is *also* required;
- All medication must be brought in original pharmacy/manufacturer labeled container by parent/guardian; **we will not administer medication without this.**

Student: _____ Date of birth: _____ Grade: _____

Name of medication: _____ Dosage: _____

Time(s) given: _____ Route (oral, eye, G-tube, etc.): _____

Stop date: _____ Reason for medication: _____

Explain possible side effects or other special instructions: _____

_____

Practitioner's Name:_____ Clinic:_____

Phone:_____ Fax: _____

I hereby give permission for school district personnel to administer the medication/treatment(s) **I have provided** for my child, according to the directions stated and authorize them to contact the practitioner if there is a question concerning the administration of this medication. I further authorize the practitioner to render treatment to my child, as appropriate and necessary, arising out of administration of the medication. Authorization is hereby granted to release information to appropriate school district personnel and classroom teachers. **I agree to hold the Winneconne Community School District, its employees or agents who are acting on this authorization, harmless in any and all claims arising from the administration of this medication at school. I also agree to inform the school immediately and in writing of any change or discontinuation of this order.** I shall pick up any unused portions of the medication/treatment within 3 business days of completion of the school year or when this order has been discontinued. *I acknowledge that the medication/treatment supplies will be destroyed if it has not been picked up after 5 business days.*

***Parent/guardian signature**:_____ **Date**:_____

Best contact for medication refill: _____
(phone/email)

Can we leave a voicemail? Y N Location of medication:_____
(Backpack, health room, classroom)

### PRACTITIONER AUTHORIZATION

The practitioner whose signature follows hereby authorizes school district personnel to administer medication as prescribed and also agrees to accept communication regarding the administration procedures. It is understood that the medication will be given by non-licensed, but specially trained personnel, and *the reason(s) that the medication must be given during the school day should be given.*

☐ Checking this box indicates the medication may be carried by the student per section 118.291 & 118.292 (Wisc.Stats.), and the student has demonstrated proper use of medication (applies ONLY to Rescue inhalers & Epinephrine auto-injectors)

Medical rationale for medication to be given during the school day: _____

_____

_____

Practitioner signature: _____ Date: _____

*Revision: 4-23*

*Practitioner* is defined as any physician, dentist, optometrist, physician assistant, advanced practice nurse practitioner or podiatrist licensed in any state