KENOSHA COUNTY SCHOOLS
MEDICATION AUTHORIZATION FORM

Prescription Medication: Physician to complete Part A. Parent/Guardian to complete Part B. Return form to school. Additional forms are available at school office.

Non-Prescription Medication: Parent/Guardian to complete Part B only.

PART A – ONE MEDICATION PER FORM

Notice to school employees administering medication as designated by school officials to provide the following medication to the student as directed below.

Student Name: ______________________________
Medication: ______________________________
Dosage: ______________________________
Route: ______________________________
Time(s) Administered: ______________________________
Reason for Medication: ______________________________
Student may carry medication for Emergency purposes: ______ Yes ______ No
Give medication on: ______ empty stomach ______ full stomach ______ not applicable
Additional directions/symptoms: ______________________________

NOTE: Designated school staff who dispense medication to the above student may call me at any time with questions or concerns related to this student's medical condition and medication.

DOCTOR'S SIGNATURE: ______________________________ DATE: ____/____/____
DOCTORS NAME (Please Print): ______________________________
ADDRESS: ______________________________ PHONE: ______________

PART B – ONE MEDICATION PER FORM

I hereby give permission to school employees designated by school officials to give medication to my child according to the following directions.
I further give permission to school authorities to contact my child's physician regarding this medication. I will notify the school in writing at the termination of this request or when any medication changes occur.

Student Name: ______________________________ Grade: __________
Name of Medication: ______________________________
Dosage to be Given: ______________________________
When to be given and how often: ______________________________
Reason for Medication: ______________________________
Additional Information: ______________________________

I have read the Criteria for Dispensing Medication at school on the back of this page and agree to meet this criteria. ALL medication must be in a properly labeled container.

PARENT SIGNATURE: ______________________________ DATE ____/____/____
DAYTIME PHONE NUMBER: ______________________________

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CRITERIA FOR DISPENSING MEDICATIONS

1. Students requiring medication at school shall have on file a completed "Medication Authorization Form" prior to medication administration.

2. All medication authorization forms shall be renewed annually and updated for all changes in medication, dosage or administration time.

3. Prescription medications must be supplied in the original pharmacy container with the original pharmacy label. Non-prescription medication must be in the original container with the directions and student's name.

4. It is the responsibility of the parent/guardian to provide and deliver to the school all authorized medications and replace expired medication. All unclaimed medication at the end of the school year will be disposed per district policy.

5. School personnel shall under no circumstances provide any medication to students without meeting the criteria in 1-4 above. Diagnosis and treatment of illness and the prescribing of medication are never responsibilities of a school and shall not be practiced by any school personnel.

6. It is the responsibility of the parent/guardian to notify school personnel of pertinent medical information regarding their child. Students with a potential life threatening health condition may be excluded from school until required medication, medication authorization form and staff training are in place at school.