KENOSHA UNIFIED SCHOOL DISTRICT NO.1

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 is in place at school.

KENOSHA UNIFIED SCHOOL DISTRICT NO.1

MEDICATION AUTHORIZATION FORM

SCHOOL NAME: ________________________ PHONE __________ FAX ____________

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.

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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 dispenses 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: ________________

DOCTOR NAME (Please Print): ____

ADDRESS: ______________________________________ PHONE:_____________ FAX: ______________

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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 Medications at school on page 2 and agree to meet these criteria. ALL medication must be in a properly labeled container.

PARENT SIGNATURE: ____ DATE: ________________

DAY TIME PHONE NUMBER: ____