EAU CLAIRE AREA SCHOOL DISTRICT

# CHILD/STUDENT MEDICATION MANAGEMENT

## PART A - MEDICATION INSTRUCTIONS FORM

**PHYSICIAN /LICENSED PRESCRIBER INSTRUCTIONS TO PARENT/GUARDIAN**

**Name of Child/Student _____ Birthdate_____**

**School Child/Student Attends_____ Grade_____**

**Child/Student's Condition/Diagnosis_____**

**For this diagnosis, I have prescribed the following medications: (**ENTIRE school year includes summer school sessions following the current school year)**

***By ECASD policy staff may administer medications only within 30 minutes before or after the prescribed time.**

| DAILY MEDICATIONS | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Medication** | **Route** | **Total Dose** | **Clock Time Please<br>Frequency (Time of Day)** | **Duration:<br>Check box for ENTIRE school year ☐<br>Or specify dates below** | **Direct contact shall be made with me should the Child develop any of the following conditions or reactions to the medication, (if none, so state)** | **Student may carry?<br>Yes/No** | **Student may self-administer?<br>Yes/No** |
| | | | | **From:<br>To: year** | | | |
| | | | | **From:<br>To:** | | | |
| | | | | **From:<br>To:** | | | |

| PRN MEDICATIONS (as needed) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Medication** | **Route** | **Total Dose** | **Frequency (Times of Day)** | **Duration:<br>Check box for ENTIRE school year ☐<br>Or specify dates below** | **Condition under which medication should be given** | **Direct contact shall be made with me should the Child develop any of the following conditions or reactions to the medication, (if none, so state)** | **Student may carry?<br>Yes/No** | **Student may self-administer?<br>Yes/No** |
| | | | | **From:<br>To:** | | | | |
| | | | | **From:<br>To:** | | | | |
| | | | | **From:<br>To:** | | | | |

**Additional directions/instructions: _____**

_____

**NOTE: PLEASE CALL ME AT ANY TIME FOR QUESTIONS THAT YOU HAVE CONCERNING YOUR CHILD'S DIAGNOSIS, THE MEDICATIONS PRESCRIBED OR REACTIONS TO THE MEDICATIONS. IF YOUR CHILD WILL BE RECEIVING MEDICATIONS DURING THE DAY AT SCHOOL, THE DESIGNATED SCHOOL PERSONNEL CAN CALL ME AT ANY TIME WITH QUESTIONS OR CONCERNS RELATED TO THE STUDENT'S CONDITION AND MEDICATIONS.**

**I WILL HAVE TO COMPLETE A NEW MEDICATION MANAGEMENT FORM (PART A - MEDICATION INSTRUCTIONS) WHEN THERE ARE CHANGES IN THE MEDICATION OR IN THE ADMINISTRATION OF MEDICATION FOR THIS CHILD/STUDENT.**

**Physician/Licensed Prescriber Signature_____Date_____**

**Physician/Licensed Prescriber Printed Name_____Phone_____**

**Physician/Licensed Prescriber Address _____Fax No._____**

EAU CLAIRE AREA SCHOOL DISTRICT

**CHILD/STUDENT MEDICATION MANAGEMENT**

**PART B - MEDICATION CONSENT FORM**

**PARENT/GUARDIAN CONSENT**

**Name of Child/Student_____ Birthdate_____**

**School Child/Student Attends_____ Grade_____**

**Child/Student's Condition/Diagnosis_____**

**I agree to:**

- **Follow the instructions of my Child's physician/practitioner ("licensed prescriber") and grant permission for unlicensed assistive school personnel to administer medication to my Child according to the instructions written by the licensed prescriber in the "Child/Student Medication Management: Part A - Medication Instructions" form (ATTACHED PART A FORM) and grant permission for school personnel to communicate with my child's licensed prescriber whenever necessary.**
- **Acknowledge that in accordance with ECASD policy staff may administer medications only within 30 minutes before or after the prescribed time.**
- **Give consent for the free exchange of any necessary information between the licensed prescriber and school personnel.**
- **Hold the Eau Claire Area School District, its employees and agents who are acting within the scope of their duties, and the licensed prescriber and its employees harmless in any and all claims arising from the administration of or exchange of information regarding the medications noted on the attached Part A Form at school or at school-related events.**
- **Notify the school in writing at the termination of this request or when there is ANY change in the licensed prescriber medication instructions. I understand that the licensed prescriber medication instructions and my consent are in force only for the current school year and summer immediately following.**

**I agree and accept my responsibilities regarding school administration of medication to my Child, that is, to:**

1. **Notify the school of my Child's needs.**
2. **Complete this "Medication Consent Form" (Part B of Child/Student Medication Management), which grants the school permission to administer medication to my Child in the dosage prescribed and to communicate directly with the licensed prescriber. This "Medication Consent Form" is valid only for the current school year and the summer immediately following.**
3. **Deliver the licensed prescriber written instructions (Part A), this parental authorization (Part B), and the initial supply of medication to the school.**
4. **Make sure that each prescribed medication is in its original pharmacy-labeled package which includes the student's name, dosage of medication, time(s) that the medication is to be administered, and the licensed prescriber's name. Over-the-counter medications must be supplied in the original manufacturer's container that lists the ingredients and recommended dose.**
5. **Obtain additional written instructions from the licensed prescriber and deliver them to the school each time there is a change in medication, dosage, or time that the medication is to be administered.**
6. **Assume full responsibility for the safe delivery of medications to appropriate school personnel.**
7. **Notify the school, in writing, if the medication is discontinued during the school year.**

**MY SIGNATURE INDICATES THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION.**

**Parent/Guardian Signature_____Date_____**

**Parent/Guardian Printed Name_____Phone_____**

**Parent/Guardian Address_____Fax No._____**