DISTRIBUTION OF MEDICATION AT SCHOOL

Dear Parent/Guardian,

Ideally, all medication should be given to students at home. However, since that is not always possible, school personnel can assist a student during the day. Only those medications which are necessary to maintain the student in school, and which must be given during school hours, will be administered. In order for school personnel to administer medication to a student, the school district’s “Authorization to Administer Medication” form must be completed and on file in the school office. This form must be completed annually for students receiving ongoing medications.

Our schools take every precaution that medicine taken by children in our care is prescribed and controlled in such a manner as to avoid oversights that might endanger a student’s health. Medication(s) will not be administered to your student without the “Authorization to Administer Medication” form that has been completed by your physician. Please note that all medications must be in the labeled prescription container and in the same dosage described on the medication form. Please do not ask us to administer any medication (including non-prescription drugs such as cough medicine, ear drops, aspirin, etc.) not prescribed by your physician. Board policy prohibits us from doing so.

High school students may self administer medication. Elementary and middle school students may self administer only emergency medications such as Epi Pens and inhalers with the approval of the parent and physician.

Should you have any questions about this policy, you may review it at (http://board-policy.wlcsd.org, policy #JGFGB. Your understanding and cooperation are appreciated.

Sincerely,

Christopher J. Delgado
Deputy Superintendent of Schools

We’re making tomorrow!
AUTHORIZATION TO ADMINISTER MEDICATION

Permission Form for Prescribed Medication and Over-the-Counter Medication.
This Authorization is Valid for the Current School Year Only.

TO BE COMPLETED BY THE PARENT/GUARDIAN

Student: ______________________________ Date of Birth: _________ Grade: _______ 
School: ______________________________ Teacher/Classroom: _______________________

I have read the policy and regulations pertaining to administration of medication. I request that (name of student) __________________________ receive the medication specified below at school according to standard school policy. I understand the parent is required to deliver medication to school.

Date __________________________ Parent/Guardian Signature ________________________

Self Administration: High school students may self administer medication. Elementary and middle school students may self administer only emergency medications such as Epi Pens and inhalers with the approval of the parent and physician. I request that (name of student) ______________________________________________________________________ be allowed to self-administer the medication below at school according to school policy.

Date __________________________ Parent/Guardian Signature ________________________

TO BE COMPLETED BY THE PHYSICIAN OR AUTHORIZED PRESCRIBER:

Name of Medication: ______________________________
Reason for Medication (optional): ______________________________
Form of Medication/Treatment: [ ] Tablet/Capsule  [ ] Liquid  [ ] Inhaler  [ ] Injection  [ ] Nebulizer  [ ] Other

Instructions: (Times and dose to be given at school): ______________________________

Start: [ ] Date form received  [ ] Other date: ______________________________
Stop: [ ] End of school year  [ ] Other date/duration: ______________________________
Stop: [ ] End of summer program

Restrictions and/or adverse reactions:
[ ] None anticipated  [ ] Yes. Please describe: ______________________________

Special storage requirements: [ ] None  [ ] Refrigerate  [ ] Other: ______________________________

This student is both capable and responsible for self-administering this medication.
[ ] No  [ ] Yes, Supervised  [ ] Yes, Un supervised

This student may carry this medication: [ ] Yes  [ ] No

PLEASE PRINT:

Physician’s Name: ______________________________ Date: ______________________________
Address: ______________________________
Phone Number: ______________________________ Physician’s Signature: ______________________________

Office Use Only:
Date received: __________________ Received by: __________________
Administrative Approval: ____________________

7/8/96
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