

WCASD Medication Authorization Form

School Year \_\_\_\_\_

Student: \_\_\_\_\_ DOB: \_\_\_\_\_ Grade: \_\_\_\_\_

To be completed by MD/DO/CRNP:

Diagnosis of condition	Medication	Dose/Time/Route/Stop date

Other Instructions:

\_\_\_\_\_ Daily medication **may be skipped** on field trips.

\_\_\_\_\_ **Only** for auto-inject epinephrine/rescue inhaler; student may self-carry and administer. (Patient has proven competency in administering and knowing signs and symptoms of when to use rescue medication. Permission also contingent on passing WCASD proficiency exam.)

\_\_\_\_\_  
Signature of Licensed Health Care Provider

\_\_\_\_\_  
Printed name of Licensed Health Care Provider

\_\_\_\_\_  
Date

Address: Phone# Fax# \_\_\_\_\_

Parent/Guardian Medication Authorization

1. *Only Inhalers and Epinephrine auto-injectors will be routinely sent on field trips.*
2. *I give permission to the school nurse to administer the above medication(s) and/or perform treatment(s).*
3. *I understand that school nurse cannot administer the medication(s)/treatment(s)/procedure(s) indicated on this form without authorization from both my student's physician/licensed prescriber and guardian/parent.*
4. *I give permission for the school nurse to consult with this student's licensed health care provider regarding questions about the above medical condition(s) and medication/procedure being used to treat the condition.*
5. *I give permission for the school nurse to communicate **as needed** with school staff about my student's health condition(s) and the action of the medication and/or treatment.*

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian name (please print) \_\_\_\_\_ Tel # \_\_\_\_\_

**SEE BACK OF FORM FOR MEDICATION REQUIREMENT**

## WCASD STUDENT MEDICATION REQUIREMENTS

Dear Parent or Guardian:

The following requirements **must** be met before any medication will be administered to your child while he/she is in the school setting. For the safety of all students, it is essential that all medications are stored in a locked cabinet in the Nursing Office. (See WCASD Board Policy 210, Medications)

### **ALL PRESCRIPTION MEDICATIONS-** DAILY, TEMPORARY, SHORT TERM, and OCCASIONAL

1. A Health Care Provider's **(MD, DO, CRNP) written order** for the nurse must accompany the medication, including date, time of medication, and dosage. **A new order is required at the start of each school year.** A pharmacy label and/or a stamped order **do not** meet the state requirements of a written HCP's signature. A new prescription order is also needed for any medication dosage or time change. When a medication is discontinued, we also request the parent/ guardian provide us with a written order from the Health Care Provider.
2. A **parent/guardian note** and/or signature, is required.
3. Medication must be clearly labeled in the **original, most current container** from the pharmacy and label must include:
  - a. Student's Name, Medication, Dosage
  - b. Instructions for Administration
  - c. Health Care Provider's Name

\*We suggest the pharmacist supply two labeled containers, one each for home and school.

### **NON-PRESCRIPTION MEDICATIONS**

- A Health Care Provider's **(MD, DO, CRNP) written order** for the nurse **must** accompany any medication other than generic Tylenol, ibuprofen, antacids, and Benadryl for serious allergic reactions. (WCASD nurses already have standing orders for these medications from the district's consulting physician).
- A **parent/guardian signature** requesting the medication administration with instructions must be provided.
- For your child's safety, medication must be in the **original, labeled container**. The expiration date must be evident.
- **Only** over the counter medications, homeopathic remedies and dietary supplements described in the current edition of the PDR for non-prescription/homeopathic drugs will be administered.

### **NO MEDICATION WILL BE ADMINISTERED UNLESS ABOVE REQUIREMENTS ARE MET**

Medications given less than 4 times/day should be administered at home, unless otherwise ordered by the Health Care Provider. Please notify your school nurse of any changes in your child's health status so that they can provide the best care.