CHILD/STUDENT MEDICATION MANAGEMENT FORM

PART A: Prescription Medication Instructions Form

To be filled out by the child's Physician/Licensed Provider.

Name of Child/Student:	Date of Birth:	Grade:	School:
Condition/ Diagnosis of Child:			

For the condition/diagnosis listed above, I have prescribed the medications listed below:

Note: 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 Name:	Route:	Total Dose:	Frequency and Time(s) of day	Duration: Entire School Year *(write ESY below)* OR Specific Dates *(write dates below)*	Contact me if child develops any of the conditions or reactions to medication listed below *(if none, write n/a)*	Student may carry?	Student may self-administer?
						☐ Y ☐ N	☐ Y ☐ N
						☐ Y ☐ N	☐ Y ☐ N
						☐ Y ☐ N	☐ Y ☐ N
						☐ Y ☐ N	☐ Y ☐ N
PRN (As Needed) MEDICATIONS							
Medication Name:	Route:	Total Dose:	Frequency and Time(s) of day	Duration: Entire School Year *(write ESY below)* OR Specific Dates *(write dates below)*	Contact me if child develops any of the conditions or reactions to medication listed below *(if none, write n/a)*	Student may carry?	Student may self-administer?
						☐ Y ☐ N	☐ Y ☐ N
						☐ Y ☐ N	☐ Y ☐ N
						☐ Y ☐ N	☐ Y ☐ N
						☐ Y ☐ N	☐ Y ☐ N

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 give me a call at any time with questions or concerns related to the student's conditions and medications.

I acknowledge I will have to complete a new *Child/Student Medication Management Form Part A: Prescription Medication Instructions*, when there are changes in the medication or in the administration of medication for this child/student.

Physician/Licensed Provider PRINTED Name:_____ Phone:_____

Clinic Name and Address:_____

Physician/Licensed Provider Signature:_____ Date:_____

CHILD/STUDENT MEDICATION MANAGEMENT FORM

PART B: Parent/Guardian Medication Consent Form

Name of Child/Student:	Date of Birth:	Grade:	School:
Condition/ Diagnosis of Child:			

I agree to:

- Follow the instructions of my child's physician/practitioner ("licensed prescriber") and grant permission for unlicensed assistive personnel to administer medication to my child according to the instructions written by the licensed prescriber on the *Child/Student Medication Management Form Part A: Prescription Medication Instructions* (ATTACHED) 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 (ECASD), 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 *Child/Student Medication Management Form Part A: Prescription Medication Instructions* 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, or for the dates listed on the *Child/Student Medication Management Form Part A: Prescription Medication Instructions*.

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

- Notify the school of my child's needs.
- Complete and sign this form, which grants the school permission to administer medication to my child in the dosage prescribed and to communicate directly with the licensed prescriber. This form is valid only for the current school year and the summer immediately following, or for the dates listed on the *Child/Student Medication Management Form Part A: Prescription Medication Instructions*.
- Deliver the licensed prescriber written instructions (Part A), this parental/guardian authorization (Part B), and the initial supply of medication to the school.
- 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 container that lists the ingredients and recommended dose.
- 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.
- Assume full responsibility for the safe delivery of medications to appropriate school personnel.
- 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 PRINTED Name:_____

Parent/Guardian Email Address:_____ Parent/Guardian Phone:_____

Parent/Guardian Signature:_____ Date:_____