Denmark School District Policy
Administration of Medication in School
Revised 5/99

Ideally, all medication should be given at home; however, occasionally a student would be able to attend school if a required medication could be given during school hours. In order to meet the student’s needs, the following medication policy guidelines are necessary.

No prescription medications will be administered by school personnel until the following forms are completed and returned to school:

1. Parental Medical Consent Form
2. Physician Request for Medication Administration Form

No non-prescription medications (over-the-counter) medications will be administered by school personnel until the following form is completed and returned to school:

1. Parental Medical Consent Form

Other Requirements:

• **All medications will be dispensed from the office.** Students are not allowed to carry medication on their person for their safety as well as the safety of the other students. Students requiring medication at school shall be identified by parents to the principal or school office.

• **Medication must be sent to school in the prescription bottle for prescribed medicine and the original container for over-the-counter meds.** Please do not send medication in envelopes, plastic bags or other containers. Pharmacies will prepare a separate bottle of medication for school use, just ask them.

• **Parental and Physician consent forms,** as well as copies of the entire medication policy are available through the school offices.

Please contact me with any questions or concerns you may have at 863-4032.

Cindy Weller R.N.
Denmark District Nurse
PARENT/GUARDIAN MEDICATION REQUEST FORM

Full name of child to be medicated: ___________________________________

Grade: __________________

Name of drug and dosage to be given: _________________________________

Hour(s) medication is to be given: _____________ Number of days: _______

Physician prescribing medication: ___________________________ Phone: _______

Reason for medication: _____________________________________________

I hereby give permission for school personnel to give the medication(s) to my child according to the directions stated above and further authorize them to contact the child’s physician. I agree to hold the Denmark School District, its employees and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication at school.

______________________________________________
Signature of Parent/Legal Guardian               Date

Address

NOTE

Before prescribed medication(s) will be administered by the school, a Physician Request for Medication Form shall be completed and returned to the school principal or school nurse. This completed form shall be accompanied by the Parent/Guardian Medication Request Form.

This form (Parent/Guardian Medication Request) must also be completed for the administration of non-prescription (over-the-counter) medications.

All medications will be dispensed from the office. Students are not allowed to carry medication on their person, for their safety as well as the safety of other students.

Students needing emergency inhalers are allowed to carry them ON THEIR PERSON, but need to have their physician indicate this on the Physician Request Form. Please notify Cindy Weller RN, District Nurse at 920-863-4032, if the student will be carrying the emergency inhaler.

Source: Denmark High School
        450 N. Wall Street
        Denmark, WI  54208
PHYSICIAN’S REQUEST FOR MEDICATION ADMINISTRATION FORM

Date Order Effective: ___________
To: ___________

To: Designated High School Employee - Sheri Kittell  Fax 920-863-8856

Name of Student: _____________________________  Phone: _______________

Address: __________________________________________________________________________

School: _____________________  Grade: ______  Teacher: ___________________

Physician’s Name: _______________________________  Phone: _______________

Physician’s Address: ____________________________________________________________________

Diagnosis: ___________________________________________________________________________

Medication/dose/route/frequency/duration ___________________________________________________

Check One: ___________ Short Term  ___________ Long Term

If a student will be keeping an emergency inhaler on his/her person, please indicate here: ___________Yes ___________No

State the specific conditions under which contact should be made with you in relation to the condition or reactions of the student receiving the medication.

____________________________________________________________________

____________________________________________________________________

NOTE
Your signature on this document attests to your willingness and intent to direct, supervise, decide, inspect and oversee the administration of the medication by the non-medically trained designated school employee and that you will accept direct communications from them regarding the administration of the medication. We urge that all instructions be stated in language of the lay person.

_______________________________________  _________________________
Signature of Physician  Date

Source: Denmark School District
450 N. Wall Street
Denmark, WI  54208