ELLSWORTH COMMUNITY SCHOOL DISTRICT HEALTH SERVICES

Dear Parent(s) / Guardian(s),

You have asked school personnel to give your child his/her medication during school hours. In order to do so, we need you to complete the information on the reverse side of this letter. Physician Signature is only required for prescription medications. This information is necessary to comply with Section 118.29 of the Wisconsin Statutes.

The medication must be sent to school in the original container. It should be clearly labeled with the child's name, name of the medication and dosage, time medication is to be given, and if it is a prescription medication, the physician's name and pharmacy telephone number.

All prescription medications must be brought in by a parent, guardian or designated adult, and counted with the secretary. Please only bring in an appropriate amount of tabs needed. Please note that most temporary medications such as Antibiotics ordered for 3 times a day can be given at home. Before school, after school, and before bed.

Inhalers, by law, can be carried by the student provided that a medication permission form signed by the physician and parent/ guardian is on file at the school.

We would prefer to give only those medications that are necessary during the school day. Also, if there is any change in the medication, a new consent form is needed.

If you have any questions, please free to contact me with any questions at 715-273-3911

Thank you,

Amy Duchnowski, RN
District School Nurse
Ellsworth School District

ELLSWORTH COMMUNITY SCHOOL DISTRICT HEALTH SERVICES

Amy Duchnowski, RN
P.O. BOX 1500, ELLSWORTH, WI 54011
Office: 715-273-3911, Fax: 715-273-3909

Medication Administration Authorization Form

Name: _____ DOB: _____ Grade: _____

Medication/ Dosage	Route	Frequency/ Time of Day	Start Date	Stop Date	Considerations/Side Effects
1.					
2.					
3.					

APPROVAL FOR STUDENT CARRYING AN INHALER and/or EPINEPHRINE AUTO-INJECTOR
Student has been trained in use of inhaler and/or epinephrine auto injector (circle) and is responsible for self-administration and will carry it with him/her. YES _____ NO _____

Print Medical Provider Name: _____ Date: _____

Physician Signature: _____
Hospital/ Clinic/ Office _____ Phone: _____

I hereby give permission to a designated school employee to give the medication(s) to my child according to the direction as stated above and further authorize them to contact the child's physician, if necessary. I understand that the medication must be delivered to school in the original packaging/bottle and medication not picked up at the end of the school year will be disposed of by school personnel. I understand that according to Wisconsin Statute 118.29 (2) that the designated school employee is immune from civil liability for his or her acts or omissions in administering a drug or prescription drug to a pupil unless the act or omission constitutes a high degree of negligence. This immunity does not apply to health care professionals.

_____ _____
Signature of Parent/ Guardian Date