KENOSHA UNIFIED SCHOOL DISTRICT NO. 1
MEDICATION AUTHORIZATION FORM

SCHOOL NAME: Dimensions of Learning
PHONE: 262-359-6849
FAX: 262-359-3134

ONE MEDICATION PER FORM


Medication to be administered as directed.

Student Name: ___________________________ DOB: ___/___/____
Medication: ____________________________________________________________
Dosage: _______________________________________________________________
Route: ________________________________________________________________
Time(s) Administered: _________________________________________________
Reason for Medication: ________________________________________________
Student may carry medication (Epinephrine/Rescue Inhaler only) for Emergency purposes: ___ Yes ___ No
Additional directions/symptoms: _________________________________________

Health Care Provider Signature: ___________________________ Date: ___/___/____
Health Care Provider Name: (Please Print): ______________________________
Address: _____________________________________________________________
Phone: __________________ Fax: __________________

NOTE: Parent/Guardian signature permits designated school staff to dispense medication to the above student and to contact the health care provider at any time with questions or concerns related to this student's medical condition and medication.

Parent/Guardian Signature: ___________________________ Date ___/___/____
Parent/Guardian Name: (Please Print): ________________________________
Daytime Phone Number: __________________________

CRITERIA FOR DISPENSING MEDICATION

1. **Authorization:** Students requiring medication at school, including herbal and vitamin supplements, shall provide a completed “Medication Authorization Form”. Prescription medications require a signature from **both** a health care provider and parent/guardian. Non-prescription medications require the parent/guardian signature. The parents must notify the school when the drug is discontinued or for any changes. An updated medication authorization form is required for all changes in medication, dosage or administration time. All medication authorization forms must be renewed annually. All unclaimed medication at the end of the school year will be disposed of per policy.

2. **Container:** All medication must be supplied in the original container. Prescription medications require the pharmacy label. Non-prescription medication must be in the original container with the directions on the container including student name. All medication shall be kept in a locked cabinet.

3. **Delivery to School:** It is the responsibility of the parent/guardian to provide and deliver to the school all authorized medication and replace expired medication.