AUTHORIZATION FOR ADMINISTRATION OF NON-PRESCRIPTION MEDICATION

Sweetwater County School District Number One, State of Wyoming Policy File JHCD requires that nonprescription medication shall not be administered to students in school without the written permission of the parent, legal guardian or student of legal age. If it is necessary for non-prescription medication to be administered during school hours, please provide the information requested and return the signed authorization to the school. **A new authorization is required for each school year.**

Student Name:_____ Birth date: _____

School:_____Grade:_____

Medication allergies/sensitivities:_____

List any other medications your child receives:_____

Medical/health problems:_____

As the parent, legal guardian or student of legal age, I authorize the above-named student to receive any medication listed below as deemed necessary by the School Nurse or her designee. I understand that generic equivalent medications may be used in accord with established protocols of the District. In consideration of District personnel administering such medication, as designated friends in accord with Wyo. Stat. §33-21-154, the undersigned hereby releases the District from any and all claims, demands and liabilities which may result by reason of the administration of such medication, the failure to administer it, or the improper administration thereof.

I would like the following non-prescription medication(s) made available to my student: (please check)

For headache/fever/burns
earache/muscle aches/
pain/menstrual cramps

___Acetaminophen
(like Tylenol)
Dosage:_____

___ Ibuprofen
(like Advil)
Dosage:_____

Sore throat/Cough
___Cough drop

Upset stomach/Heartburn
___ Chewable antacid
(like Tums)
Dosage_____

Itching/rash
____Hydrocortisone Cream

Minor Allergic Reaction
____Diphenhydramine
(like Benadryl)
Dosage:_____

____ I do not want any non-prescription medication given to my child at school.

Parent/Guardian's Signature: _____ Date: _____

Parent/Guardian's Phone: Home: _____ Work: _____

AUTHORIZATION FOR ADMINISTRATION OF PRESCRIPTION MEDICATION

Sweetwater County School District Number One, State of Wyoming Policy File JHCD requires that no prescription medication shall be administered to students in school without the written permission of both the student's licensed healthcare professional authorized to write prescriptions and the parent, legal guardian or student of legal age. By signing below, the parent, legal guardian or student of legal age hereby grants permission for the building principal or school nurse to contact the licensed healthcare professional listed below for patient records, medical history, or information on medication and dosage as needed. If it is necessary for medication to be administered during school hours, please provide the information requested and return this signed authorization to the school. **A new authorization is required for each school year.**

Student name: _____Grade: _____

Medication name and dosage: _____

Time(s) to be given: _____

Reasons for taking: _____

Special storage or security information: _____

Licensed Healthcare Professional's specific precautions (side effects) and actions to be taken:_____

_____

Licensed Healthcare **Professional Authorized to Write Prescriptions Signature**:

_____Date: _____

As the parent, legal guardian or student of legal age, I authorize the above-named student to receive the identified medication and agree to provide the medication in a properly labeled pharmaceutical container within which it was originally prescribed (pharmacists will provide extra containers labeled for school administration). The amount of medication to be kept at school for the student should be appropriate to the needs of the student. In consideration of District personnel administering such medication, as designated friends in accord with Wyo. Stat. §33-21-154, the undersigned hereby releases the District from any and all claims, demands and liabilities which may result by reason of the administration of such medication, the failure to administer it, or the improper administration thereof.

Parent/Guardian's Signature:_____Date:_____

Parent/Guardian's Phone: (Home) _____(Work) _____

Student of Legal Age Signature: _____ Date:_____

SELF-ADMINISTERED MEDICATION

Inhaler Authorization – Licensed Healthcare Professional's Signature Required. The above named student has my permission to carry his/her prescribed inhaler for self-administration of the medication.
Licensed Healthcare Professional's Signature: _____Date: _____

Inhaler Exception – Parent/Guardian's Signature Required. The student has been instructed in the proper use and care of the above identified inhaler. I request that the student be permitted to carry and self-administer the inhaler.
Parent/Guardian's Signature:_____ Date:_____
Student of Legal Age
Signature:_____Date:_____

MEDICATIONS IN EMERGENCIES

Emergency Medical services (911) will be activated in the event that Epinephrine, Diastat, or Glucagon is administered and parents will be notified immediately.

- Epinephrine injection for severe allergic reactions.
- Diastat rectal gel for prolonged seizures lasting longer than 5 minutes affecting breathing**.**
- Glucagon injection for Hypoglycemia (low blood sugar).

The emergency use of oxygen is administered only in exceptional circumstances.
Sweetwater County School District Number One
State of Wyoming
Board Policy JHCD-E
Revised: November 20, 2010