Ripon Area School District

Medication/Treatment Authorization Form

Phone Number: 920-748-4635
Fax Number: 920-748-4620

All portions of the Medication/Treatment Authorization Form must be completed before medication can be administered by school district personnel. Incomplete forms may result in the form being returned for full completion.

Keep in mind:

- All prescription medications require **BOTH** a practitioner signature and a parent/guardian signature;
- All over-the-counter medication requires **ONLY** parent/guardian signature, unless outside of the recommendations of the manufacturer, in which case a practitioner signature is also required.
- All medication must be brought in the original pharmacy/manufacturer labeled container by parent/guardian. W**e will not administer medication without this.**

Student:		Date of Birth:
School (circle): BPES MPES RMS RHS	Grade:	Teacher:
Name of medication:	Dosage:	Time(s) given:
How administered (oral, injection, inhaler, topical, other):		Stop date:
Reason for medication:		
Explain possible side effects or other special instructions:		

I hereby give permission for Ripon Area School District personnel to administer the medication/treatment(s) **I have provided** for my child, according to the directions stated and authorize them to contact the practitioner if there is a question. I further authorize the practitioner to render treatment to my child, as appropriate and necessary, arising out of administration of the medication. Authorization is hereby granted to release information to appropriate school district personnel and classroom teachers. **Parent signature consents for communication between school personnel and physician regarding this medication and any concerns arising from such. I agree to hold the Ripon Area School District, its employees or agents who are acting on this authorization, harmless in any and all claims arising from the administration of this medication at school. I also agree to inform the school immediately and in writing of any change or discontinuation of this order.** I shall pick up any unused portions of the medication/treatment within 3 business days of completion of the school year or when this order has been discontinued. *I acknowledge that the medication/treatment supplies will be destroyed if it has not been picked up after 5 business days.*

Parent Signature:	Date:
Best contact for medication refill (phone or email):	Should medication be given on early release days?
Can we leave a voicemail at that number?	Where will inhaler/Epi-injector be stored?

PRACTITIONER AUTHORIZATION

The practitioner whose signature follows hereby authorizes Ripon Area School District personnel to administer medication as prescribed and also agrees to accept communication regarding the administration procedures. It is understood that the medication will be given by non-licensed, but specially trained personnel. ☐ **Checking this box indicates the medication may be carried by the student per section 118.291 & 118.292 (Wisc. Stats.), and the student has demonstrated proper use of medication (applies ONLY to rescue inhalers & Epinephrine auto-injectors)**

Practitioner signature:	
Printed Name:	Date:
Affiliation:	Phone:
Medical Rationale for administration at school	