

AUTHORIZATION FOR ADMINISTRATION OF PRESCRIPTION MEDICATION

Sweetwater County School District Number One, State of Wyoming, Policy 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: _____

Reason(s) 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 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