WILSON AREA SCHOOL DISTRICT

Medication Administration Request and Consent Form – WA-15

Completion of WA-15 is required for the administration of prescription medication, "over the counter" medication ("OTC"), and alternative/herbal supplements by District Responsible Personnel.

For completion by Parent/Guardian

Name of student: _____ **Date of Birth:** _____
Last *First*

School: _____ **Grade/HR:** _____

In accordance with Board Policy 5146, medication(s) should be given at home before or after school. When this is not possible, the parent/guardian and the Licensed Prescriber must complete the *Medication Administration Request and Consent Form (WA-15).* Medications must be provided to the school in the original pharmacy labeled container or original container for "OTC" medications and alternative/herbal supplements. Medication must be delivered and picked up by the parent/guardian or authorized student (aged 18 or older). Parents/Guardians are responsible for noting the expiration date of medication as listed on the medication label and providing a new prescription when medication has expired or has run out.

Special Note for Emergency Medications (Epipen®, "rescue" asthma inhaler, or diabetes medication): Parent/Guardian and Licensed Care Provider should first complete this form (WA-15). In addition, Form WA-16 *(Permission to Carry and Self-Administer Emergency Medication)* should also be completed if the student will carry the emergency medication or carry and self-administer the medication. Form WA-16 is not necessary if emergency medication will only be administered by Responsible Personnel and will not be carried or self-administered by the student.

I, _____ **authorize the Responsible Personnel to administer the**
Name of parent/guardian (print)

medication _____ **as ordered by the licensed prescriber to**
Print name of Medication

my child.

_____ _____ _____
Signature of parent/guardian *Date* *Daytime Phone number*

List all medications (prescription and OTC) taken by student at home and at school:

_____

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WA Form 15

For Completion by Licensed Prescriber (Medication Order)

Special instructions for prescriber regarding orders for emergency medication such as epinephrine, "rescue" asthma inhalers, and medication for diabetes:

1) If you prescribe two doses of epinephrine for symptoms of anaphylaxis, please specify the time frame between doses. Only nursing staff may administer epinephrine that is not in the auto-injector form such as Epipen®/Epipen Jr®; therefore the second dose should also be in the form of an auto-injector (Epipen®/Epipen Jr®) instead of the Twinject® form.

2) If you believe that the student is competent to carry OR carry AND self-administer an epinephrine auto-injector (Epipen®, rescue asthma inhaler or medication for diabetes), please complete this form and also complete form WA-16 *Consent to Carry and Self-Administer Emergency Medication.*

Name of Student: _____ **DOB:** _____

Diagnosis for which medication is prescribed: _____

Name of Medication: _____

Dosage (mg/ml)/Route: _____

Time of administration/Frequency: _____

Possible side effects/adverse reactions: _____

Start Date: _____ **Discontinuation Date:** _____

Specific instructions regarding administration: _____

_____

Other medications taken at home: _____

Allergies: _____

_____ _____

Printed name of Licensed Prescriber ***Phone Number***

_____ _____

Signature of Licensed Prescriber ***Date***

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WILSON AREA SCHOOL DISTRICT

Medication Administration Request and Consent

Consent to Carry and Self-Administer Emergency Medication – WA-16

Please complete this form if the student will carry or carry and self-administer an emergency medication. Unsupervised self-administration of emergency medication refers to situations in which students carry their own medication and administer it to themselves during the school day, as ordered by their Licensed Prescriber and as authorized by their parent/guardian and in accordance with Board Policy 5146.

Name of student: _____ **Date of Birth:** _____
Last *First*

School: _____ **Grade/HR:** _____

Consent/Permission: **Please check one box from the following two options**

☐ It is necessary for my child to carry his/her own emergency medication (Epipen®/Epipen Jr®, "rescue type" asthma inhaler, emergency medication for diabetes) as listed in form WA-15. My child is competent to carry the medication but is not old enough or competent to self-administer the emergency medication.

If Responsible Personnel through professional judgment and assessment believe that the student is not capable of safely carrying the emergency medication, the parent and Licensed Prescriber will be contacted and alternate arrangements will be made.

OR

☐ It is necessary for my child to carry and self-administer his/her own emergency medication (Epipen®/Epipen Jr®. "rescue-type" asthma inhaler, emergency medication for diabetes) as listed in form WA-15. My child is competent to carry and self-administer the medication.

If Responsible Personnel through professional judgment and assessment believe that the student is not capable of safely carrying and administering the emergency medication, the parent/guardian and Licensed Prescriber will be contacted and alternate arrangements will be made.

I relieve the Wilson Area School District and its school employees, agents, officers, directors, and/or assigns of any responsibility for the benefits or consequences of the prescribed medication and acknowledge that the district bears no responsibility for ensuring that the prescribed medication is taken. The student must notify Responsible Personnel after each use of emergency medication and sign his/her medication sheet in the presence of Responsible Personnel following each use.

_____
Print name of parent/guardian

_____ _____ _____
Signature of parent/guardian ***Daytime phone number*** ***Date***

See other side

Name of student: _____ **Date of Birth:** _____
Last *First*

School: _____ **Grade/HR:** _____

To be completed by Licensed Prescriber

Name of Emergency Medication: _____

Consent to Carry Emergency Medication: **Please check ONE box from the following two options:**

☐ **Permission for student to carry (not self-administer) emergency medication**

It is necessary for the student named above to carry the prescribed emergency medication (see form WA-15). The student is capable of carrying the emergency medication.

If Responsible Personnel in the student's school, through professional judgment and assessment believe that the student is not capable of safely carrying the emergency medication, the parent/guardian and Licensed Prescriber will be contacted and alternate arrangements will be made.

OR

☐ **Permission for student to carry AND self-administer emergency medication**

It is necessary for the student named above to carry and self-administer the prescribed emergency medication (see form WA-15). The student is capable of carrying and self-administering the emergency medication.

If Responsible Personnel in the student's school, through professional judgment and assessment believe that the student is not capable of safely carrying the emergency medication, the parent/guardian and Licensed Prescriber will be contacted and alternate arrangements will be made.

_____ _____
Printed name of Licensed Prescriber ***Phone Number***

_____ _____
Signature of Licensed Prescriber ***Date***

_____ _____
Signature of School Nurse ***Date***

See other side

WILSON AREA SCHOOL DISTRICT

Consent to Carry and Self-Administer Emergency Medication on Field Trip – WA-17

Please complete this form if the student will carry or carry and self-administer emergency medication on a field trip. Unsupervised self-administration of emergency medication refers to situations in which students may carry their own medication and administer it to themselves during a field trip, as ordered by their Licensed Prescriber and as authorized by their parent/guardian and in accordance with Board Policy 5146. Parent/Guardian and Licensed Care Provider must also complete *Medication Administration Request and Consent Form (WA-15).*

Medications must be provided to the school in the original pharmacy labeled container or original container for "OTC" medications and alternative/herbalsupplements. Parents/Guardians are responsible for noting the expiration date of medication as listed on the medication label and providing a new prescription when medication has expired or has run out.

PART A: To be Completed by Parent/Guardian
(*One medication per form*)

It is necessary for my child to carry and self-administer his/her own emergency medication as listed in Part B. My child is competent to carry and self-administer the medication. If Responsible Personnel through professional judgment and assessment believe that the student is not capable of safely carrying and administering the emergency medication, the parent/guardian will be contacted and alternate arrangements will be reviewed.

I relieve the Wilson Area School District and its school employees, agents, officers, directors, and/or assigns of any responsibility for the benefits or consequences of the prescribed medication and acknowledge that the district bears no responsibility for ensuring that the prescribed medication is taken. The student must notify Responsible Personnel after each use of any medication and sign his/her medication sheet in the presence of Responsible Personnel following each use. I also acknowledge and understand the following:

1. I understand that a nurse may not be on the field trip.
2. I will provide the medication in the original container with the pharmacy label on it.
3. I will provide only the correct number of doses needed in the bottle.
4. All of the information contained in this form is true and correct.

Parent/Guardian Name (please print): _____

Parent/Guardian Signature: _____ Date: _____

Phone: (_____) _____ - _____

PART B: To be Completed by Licensed Physician/Prescriber
(*One medication per form*)

Name of Student: _____ **DOB:** _____

School: _____ **Grade:** _____

Reason for Medication/Diagnosis: _____

Name of Medication: _____

Dosage (mg/ml)/Route: _____

Time of administration/frequency: _____

Possible side effects/adverse reactions: _____

Does Student carry medication for emergency purposes? ____Yes ____No

Refrigerate medication ____Yes ____No

Start Date: _____ **Discontinuation Date:** _____

Allergies: _____

Other Medications Taken: _____

Doctor's Name (Please Print): _____

Doctor's Signature: _____ **Date:** _____

Address: _____ **Phone:** _____