



RIVER VALLEY SCHOOL DISTRICT

660 West Daley Street

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Spring Green, Wisconsin 53588

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Phone: 608-588-2551

452.4 Exhibit 1

Medication Administration Information

MEDICATION ADMINISTRATION INFORMATION RIVER VALLEY SCHOOL DISTRICT

- | | | |
|---|---------------------|-------------------|
| <input type="checkbox"/> River Valley High School | Phone: 608-588-2554 | Fax: 608-588-2827 |
| <input type="checkbox"/> River Valley Middle School | Phone: 608-588-2556 | Fax: 608-588-2026 |
| <input type="checkbox"/> River Valley Early Learning Center | Phone: 608-546-2228 | Fax: 608-588-8566 |
| <input type="checkbox"/> River Valley Elementary School | Phone: 608-588-2559 | Fax: 608-588-2550 |

Student Name: _____ Birth date: _____ Grade: _____

Parent/Guardian Name: _____ Phone: _____

PRESCRIPTION MEDICATIONS MUST BE COMPLETED AND SIGNED BY A PHYSICIAN

Diagnosis: _____

DAILY Medication:

Medicine	Dose	Route	Frequency	Duration	Side effects to be reported to Physician
1.					
2.					

PRN Medications: Administer for the following symptoms: _____

Medicine	Dose	Route	Frequency	Duration	Side effects to be reported to Physician
1.					
2.					

INHALERS: Student may carry inhaler and self-administer.

I agree to retain the power to direct, supervise, decide, inspect, and oversee the administration of the above medication(s).

Medical Provider Signature _____

Date _____

Medical Provider Name (please print) _____

Telephone # _____

Address _____

NON-PRESCRIPTION MEDICATIONS

Parent/guardian must complete the information below. If the dose exceeds the recommendations on the bottle/package, a physician's order is required.

Medication	Dosage	Frequency	Considerations	Duration
1.				
2.				
Other medications provided at school with parent/guardian permission:				
<input type="checkbox"/> Tyl Tylenol				
<input type="checkbox"/> Ibu Ibuprofen				
For students with frequent ailments (headaches, allergies, stomach aches, etc) that require frequent use of medication parent will be required to supply medication for school. Medication will be administered according to product instructions unless specified				

Parent Permission for Administration of Medication

I hereby give my permission to authorize personnel of the River Valley School District to give medication to my child as described above. I agree to hold River Valley School District and its employees and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication at school.

I hereby give permission to the school nurse to contact the child's physician, if needed. I give consent for this information to be shared with staff members with an educational right to know. I agree to contact the school nurse if any changes occur with the above request.

Parent/Guardian Signature

Date

CROSS REF.:

Policy #452.4 Administering Medication to Students

Policy #452.4-Rule 1 - Administering Medication Procedure

Policy #452.4-Rule 2 - Medication Error Procedure

Policy #452.4-Rule 3 - Disposal of Medical Waste

Policy #452.4-Exhibit 2 – Medication Incident Report Form

APPROVED: July 10, 2014

REVISED: April 11, 2019

APPROVED: May 9, 2019