# MEDICATION AUTHORIZATION FORM

## Westside Community Schools — Office of Student Services

Please PRINT Clearly

| Student Last | Student First | Date of Birth | Age |
|---|---|---|---|
| | | | |

| School | Grade | Teacher | Allergies |
|---|---|---|---|
| | | | |

### PRESCRIPTION

To be completed by physician/dentist/provider

Name of Medication 1

| Dosage | Route |
|---|---|
| | |

Time of Day/Frequency

For treatment of

Emergency procedure in case of serious side effects

Is it safe for unlicensed, trained staff to provide the medication? ☐ Y ☐ N

Name of Medication 2

| Dosage | Route |
|---|---|
| | |

Time of Day/Frequency

For treatment of

Emergency procedure in case of serious side effects:

Is it safe for unlicensed, trained staff to provide the medication? ☐ Y ☐ N

*I request and authorize that the above-named student be administered/ provided the above identified medication in accordance with instructions indicated above from _____ to _____ (not to exceed current school year) as there exists a valid health reason which makes administration of the medication advisable during school hours.*

| Physician/Provider Signature | Date |
|---|---|
| | |

| Physician/Provider PRINTED Name | Phone Number |
|---|---|
| | |

### NON-PRESCRIPTION/OVER-THE-COUNTER

To be completed by parent/guardian

Name of Medication A

| Dosage | Route |
|---|---|
| | |

Time of Day/Frequency

For treatment of

Possible side effects

Name of Medication B

| Dosage | Route |
|---|---|
| | |

Time of Day/Frequency

For treatment of

Possible side effects:

**Time frame to administer medication**

| Start Date | End Date (two-week maximum) |
|---|---|
| | |

- **NO MEDICATION WILL BE GIVEN IF NOT IN ITS ORIGINAL, PROPERLY LABELED CONTAINER.**
- **If samples of medication are to be given, they must be labeled with the student's name, dosage, route, and time(s) to be given.**
- **Non-prescription medication must be labeled with the student's name.**
- **ALL MEDICATION MUST BE DELIVERED TO AND PICKED UP FROM SCHOOL BY PARENT/GUARDIAN**

### THIS PORTION TO BE COMPLETED BY PARENT/GUARDIAN

*I request/authorize the school to give medication(s) to my child in accordance with the instructions above. I understand that unlicensed, trained staff may be assigned to provide medication(s) to my child, and I accept ultimate responsibility for monitoring the effects of the medication(s).*

*I authorize the school nurse to communicate with the health care provider as allowed by HIPAA.*

*In the event that the school grants my child permission to carry and self-administer medication(s), a separate, contractual agreement of responsibilities must be signed by student, parent, physician, and school official.*

| Parent/Guardian Signature (REQUIRED) | Date | Phone Number |
|---|---|---|
| | | |

| Nurse Signature | Health Assistant Signature |
|---|---|
| | |

Use additional forms for more medications

Form updated 2016