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