WARREN WOODS PUBLIC SCHOOLS
MEDICATION/PARENT AUTHORIZATION FORM

Student Name: _____ Birthdate:_____ Grade:_____ School Year:_____

School:_____ Date Form Received by School:_____

This form must be completed fully in order for schools to administer the required medication.
A new medication authorization form must be completed at the beginning of each school year, include the medication to be administered, and anytime there is a change in the dosage or administration time of the medication.
*Prescription medication must be in its original container, and labeled by the pharmacist or prescriber.
*Non-prescription medication must be in the original container with the label intact.
*School Nurses will call the prescriber, as allowed by HIPAA, if questions arise about the child and/or child's medication.

THIS PORTION TO BE COMPLETED BY PHYSICIAN/LICENSED PRESCRIBER:

Medication #1	Dose (mg or mg/mL)	Time to be given	Form/Route*	Side Effects	Adverse Reactions

*Routes – Oral (pill/capsule/chewable, liquid) -Inhaled (inhaler, nebulizer) -Topical (eye drops, ointment) Ear drop, injections, other – please list

List minimal frequency between doses (especially if p.r.n./as needed) _____

Reason for medication #1:_____ Special Instructions: _____

START Date-If not the beginning of the school year: _____ ***STOP Date***-if not the end of school year:_____

☐ I request that my child be assisted by authorized school personnel in taking the described medication at school according to Board of Education Policy #5330.

☐ I request that my child be allowed to self-administer the above medication at school, according to school policy.

Medication #2	Dose (mg or mg/mL)	Time to be given	Form/Route*	Side Effects	Adverse Reactions

*Routes – Oral (pill/capsule/chewable, liquid) -Inhaled (inhaler, nebulizer) -Topical (eye drops, ointment) Ear drop, injections, other – please list

List minimal frequency between doses (especially if p.r.n./as needed) _____

Reason for medication #2:_____ Special Instructions: _____

START Date-If not the beginning of the school year: _____ ***STOP Date***-if not the end of school year:_____

☐ I request that my child be assisted by authorized school personnel in taking the described medication at school according to Board of Education Policy #5330.

☐ I request that my child be allowed to self-administer the above medication at school, according to school policy.

Medication #3	Dose (mg or mg/mL)	Time to be given	Form/Route*	Side Effects	Adverse Reactions

*Routes – Oral (pill/capsule/chewable, liquid) -Inhaled (inhaler, nebulizer) -Topical (eye drops, ointment) Ear drop, injections, other – please list

List minimal frequency between doses (especially if p.r.n./as needed) _____

Reason for medication #3:_____ Special Instructions: _____

START Date-If not the beginning of the school year: _____ ***STOP Date***-if not the end of school year:_____

☐ I request that my child be assisted by authorized school personnel in taking the described medication at school according to Board of Education Policy #5330.

☐ I request that my child be allowed to self-administer the above medication at school, according to school policy.

EMERGENCY/SELF-CARRY MEDICATIONS:

☐ If based on their observation, they believe a life-threatening condition exists, I authorize school personnel to administer:

_____ Glucagon/Baqsimi _____ Epinephrine _____ Other: _____

I hereby release Warren Woods Public School and its personnel from any and all liability that may result from their determination that a life-threatening condition exists.

☐ This student is capable and responsible for carrying and self-administering

_____ Epi-Pen/Auvi-Q _____ Inhaler

(A second Epi-Pen/Auvi-Q/Inhaler must be stored in the school office)

_____ _____ _____

Physician's Signature (No stamps please) Date Physician's Printed Name

_____

Physician's Phone Number Fax Number Physician's Address

THIS PORTION TO BE COMPLETED BY PARENT/GUARDIAN:

I request and give permission for (name of child) _____ to receive the above medication(s)/treatment at school, according to standard school district policy, and for the physician(s) staff and school district staff to share information needed to assist my child with medication needs.

*I will assume responsibility for safe delivery of the medication to school, either by me or by my child

*I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment.

*I will pick-up left-over medication within 2 weeks of being notified, otherwise, I understand that it will be discarded.

*I release and agree to hold the Board of Education, its officials, and its employees, harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

_____ _____ _____

Parent/Guardian Signature Date Phone Number(s)