Authorization for Administration of Medication
(Must be completed for each medication)

Name of Student: _____ Teacher: _____

Birth Date: _____ Grade: _____ Date form Received: _____

☐ **Prescription Medication** (requires physician's signature) ☐ **Nonprescription Medication**

Name of Medication: _____

Reason for Medication: (optional) _____

Dosage: _____ Frequency: _____ Time: _____

Duration (start/stop date): _____ (if indefinite, please state)

Form of Medication/Treatment:

☐ Tablet/Capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Topical ☐ Drops ☐ Other

How is the medication to be given (schedule and dose to be given at school)? _____

_____

Should the school be aware of any restrictions or important side effects**?** ☐ None anticipated

☐ Yes (please describe):_____

The student is both capable and responsible for self-administering this medication:

☐ No ☐ Yes, supervised ☐ Yes, unsupervised

The student may carry this medication: ☐ Yes ☐ No

Information below is required for prescription medication only

Date: _____ Physician Signature: _____

Physicians Name: _____ Phone Number: _____

Address: _____

To be completed by parent/guardian:

I request that the child named above receive the medication/treatment at school according to standard school policy.

I request that (child's name) _____be allowed to self-administer the above medication at school according to school policy.

I agree to immediately notify school personnel in writing in the event the prescription shall be discontinued or modified.

I understand I must deliver this medication to the school office in its original container appropriately labeled by the physician or pharmacy.

Further, I release Williamston Community Schools and shall indemnify said school district from any liability or damage which may result to my child from the administration of said medication as prescribed by our physician.

Signature of the parent/guardian: _____ Date: _____

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