

SCHOOL MEDICATION ADMINISTRATION AUTHORIZATION FORM

This order is valid only for school year 2024-2025 including the summer session

This form must be completed fully in order for WMAES to administer the required medication. A **new** medication administration form must be completed at the beginning of each school year, for each medication including each time there is a change in dosage or time of administration of medication.

- Prescription medication must be in a container labeled by the pharmacist or prescriber
- Non-prescription medication must be in the unopened, original container with the label intact
- An adult must bring the medication to the school
- A PHYSICIAN'S SIGNATURE is needed for BOTH prescription and over-the-counter medication

Parent/Prescriber's Authorization

Student Name: _____ Date of Birth: _____ Grade: _____

Condition for which medication is being administered: _____

Medication Name: _____ Dose _____ Route: _____

Form of Medication: ___ Tablet/Capsule ___ Liquid ___ Inhaler ___ Other

Time/frequency of administration: _____

Relevant side effects: None expected ___ Yes-(please specify) _____

Medication shall be administered from _____ to _____

Prescriber's Name: _____

Telephone: _____ Fax: _____

Prescriber's Address: _____

Prescriber's Signature: _____ Date: _____

PARENT/GUARDIAN AUTHORIZATION

I request designated school personnel to administer the medication as prescribed by the above. I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. I authorize designated school personnel to communicate with the healthcare provider as allowed by HIPAA.

Parent/Guardian Signature: _____ Date: _____

Phone Number:
Home: _____ Cell: _____ Work: _____

SELF-CARRY/SELF-ADMINISTRATION OF MEDICATION AUTHORIZATION APPROVAL

Self-carry/self-administration of medication (including emergency medication) must be authorized by the prescriber

Prescriber's authorization for self-carry/self-administration of medication _____

Parent/Guardian's Authorization for self-carry/self-administration of medication: _____