WILSON SCHOOL DISTRICT AUTHORIZATION FOR SCHOOL MEDICATION ADMINISTRATION (FORM MUST BE COMPLETED IN ITS ENTIRETY)

PHYSICIAN'S REOUEST Name of medication: Reason: Reason: Reason: Reason: Reason: Reason: Reason: Reason: Reason: Redication is do be given at home: Time and dose(s) to be given at school: Medication is to be administered: Leason: Permitted completed. Dates to be given at school: PRN The parent/guardian of the physician's Signature Physician's Signature Physician's Signature Phone Number PARENT REOUEST I, the parent/guardian of Parent/guardian of Parent/guardian of Signature on this document constitutes a complete waiver of liability claim in any and all respects against the Wilson S District and its Board of Directors and all employees unless the District is negligent with regard to any claim for injuncenction with administration of the medication. Additionally, I agree to hand deliver the medication to the nurse's office in the original pharmacy or physician is changed or discontinued. I give permission for the school and physician to communicate regarding this medication is changed or discontinued. I give permission for the school and physician to communicate regarding this medication please with regard to any claim for injuncenction with administration of the medication. I believe my child is able and responsible to carry and self-administer his/her inhaler (grades K-12) and/or Egience of the school of the physician is changed or discontinued. I give permission for the school and physician to communicate regarding this medication elical condition.	D	Grade/	Homeroom:
PHYSICIAN'S REQUEST	Date of Birth:	Drug Allergies:	
Name of medication: Reason: Reason: Route: Time and dose(s) to be given at home: Time and dose(s) to be given at school: Medication is to be administered: 1until completed. Dates to be given at school: 2entire school year: DailyPRN			
Reason:		PHYSICIAN'S REQUEST	
Side Effects: Time and dose(s) to be given at home: Time and dose(s) to be given at school: Medication is to be administered: 1 until completed. Dates to be given at school: 2 entire school year: Daily PRN 3 other: I believe this child is able and responsible to carry and self-administer his/her inhaler (grades K-12) and/or Epi (grades 7-12) during school activities. S/he has permission to do so and has been instructed on how to self-administer. Physician's Signature Printed Name Date Phone Number PARENT REQUEST I, the parent/guardian of request that the employees (nurse, principal, or printed signee) of Wilson School District administer the above named medication as prescribed by my child's physician. signature on this document constitutes a complete waiver of liability claim in any and all respects against the Wilson S District and its Board of Directors and all employees unless the District is negligent with regard to any claim for injuconnection with administration of the medication. Additionally, I agree to hand deliver the medication to the nurse's office in the original pharmacy or physician la container. I also accept responsibility to provide a physician's note and my written instructions if the medication is changed or discontinued. I give permission for the school and physician to communicate regarding this medication medical condition. I believe my child is able and responsible to carry and self-administer his/her inhaler (grades K-12) and/or Epi	Name of medication:		
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nurse as soon as possible after using the medication.		on for him/her to do so. If my child uses hi	
Date Parent/Guardian Signature			
List all medications currently being taken by this child:	nurse as soon as possible after usin	Parent/	Guardian Signature