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

It is the Wilson School District's intent to ensure the maximum health and safety for all students. We realize that at times students have medical conditions which require the use of medication. **In most situations, all doses of the prescribed medications can be given at home.** However, there are times when it will be necessary for a student to receive medication during school hours.

Child's Full Name:_____ Grade/Homeroom:_____

Date of Birth: _____ Drug Allergies:_____

PHYSICIAN'S REQUEST

Name of medication: _____

Reason: _____ Route:_____

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 and/or Epi-Pen during school activities. S/he has permission to do so and has been instructed on how to self-administer.**

_____ **Okay to omit the school medication dose on field trip days.**

_____ _____

Physician's Signature Printed Name

_____ _____

Date Phone Number

PARENT REQUEST

I, the parent/guardian of _____ request that the employees (nurse, principal, or principal designee) of Wilson School District administer the above named medication as prescribed by my child's physician. My signature on this document constitutes a complete waiver of liability claim in any and all respects against the Wilson School District and its Board of Directors and all employees unless the District is negligent with regard to any claim for injury in connection with administration of the medication.

Additionally, **I agree to hand deliver** the medication to the nurse's office in the original pharmacy or physician labeled container. I also accept responsibility to provide a physician's note and my written instructions if the medication is to be changed or discontinued. I give permission for the school and physician to communicate regarding this medication and medical condition.

_____ I believe my child is able and responsible to carry and self-administer his/her inhaler and/or Epi-Pen. I give my permission for him/her to do so. If my child uses his/her inhaler or Epi-pen, he/she will notify the nurse as soon as possible after using the medication.

_____ _____

Date Parent/Guardian Signature

List all medications currently being taken by this child:_____

School Use Only

_____ Clearance to carry and self-administer an inhaler and/or Epi-Pen has been given and initialed by the school nurse.

FOR SCHOOL USE ONLY

Student's Name	Grade/Sec	Medication	Dose	Time	Method	Instructions	Type

***Chart date and initials for daily meds. Chart date, time, and initials for as needed medications.**
