WILSON SCHOOL DISTRICT
AUTHORIZATION FOR SCHOOL MEDICATION ADMINISTRATION
2021-2022 SCHOOL YEAR
(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.

Student's Full Name: _____ **Grade/Homeroom:** _____
Date of Birth: _____ **Allergies:** _____

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Name of medication: _____
Reason taking medication: _____ **Route:** _____
Side Effects: _____
Time and dose to be given at home: _____
Time and dose to be given at school: _____

Medication is to be administered:

☐ **until completed** -- (dates to be given):_____
☐ **daily for the entire school year** ☐ **PRN for the entire school year**
☐ **other :**_____
☐ I believe this child is able and responsible to carry and self-administer his/her inhaler and/or epinephrine during school activities. He/she 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 Physician's Name Printed

_____ _____
Date Physician's Phone Number

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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 the administration of the medication.

Additionally, I agree to hand deliver the medication to the nurse's office in the original pharmacy 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 epinephrine. I give my permission for him/her to do so. If my child uses his/her inhaler or epinephrine, he/she will notify the school nurse as soon as possible after using the medication.

_____ _____
Date Parent/Guardian Signature

List all medications currently being taken by this child: _____