



WARREN WOODS PUBLIC SCHOOLS MEDICATION/PARENT AUTHORIZATION FORM

Student Name: _____ Birthdate: _____ Grade: _____ School Year: _____

School: _____ Date Form Received by School: _____

This form must be completed fully in order for schools to administer the required medication.

A new medication authorization form must be completed at the beginning of each school year, include the medication to be administered, and anytime there is a change in the dosage or administration time of the medication.

*Prescription medication must be in its original container, and labeled by the pharmacist or prescriber.

*Non-prescription medication must be in the original container with the label intact.

*School Nurses will call the prescriber, as allowed by HIPAA, if questions arise about the child and/or child's medication.

THIS PORTION TO BE COMPLETED BY PHYSICIAN/LICENSED PRESCRIBER:

Medication #1	Dose (mg or mg/mL)	Time to be given	Form/Route*	Side Effects	Adverse Reactions

*Routes – Oral (pill/capsule/chewable, liquid) -Inhaled (inhaler, nebulizer) -Topical (eye drops, ointment) Ear drop, injections, other – please list

List minimal frequency between doses (especially if p.r.n./as needed) _____

Reason for medication #1: _____ Special Instructions: _____

START Date-if not the beginning of the school year: _____ **STOP Date**-if not the end of school year: _____

I request that my child be assisted by authorized school personnel in taking the described medication at school according to Board of Education Policy #5330.

I request that my child be allowed to self-administer the above medication at school, according to school policy.

Medication #2	Dose (mg or mg/mL)	Time to be given	Form/Route*	Side Effects	Adverse Reactions

*Routes – Oral (pill/capsule/chewable, liquid) -Inhaled (inhaler, nebulizer) -Topical (eye drops, ointment) Ear drop, injections, other – please list

List minimal frequency between doses (especially if p.r.n./as needed) _____

Reason for medication #2: _____ Special Instructions: _____

START Date-if not the beginning of the school year: _____ **STOP Date**-if not the end of school year: _____

I request that my child be assisted by authorized school personnel in taking the described medication at school according to Board of Education Policy #5330.

I request that my child be allowed to self-administer the above medication at school, according to school policy.

