Wheaton Area Schools #803

AUTHORIZATION FOR PRESCRIBED MEDICATIONS

STUDENT INFORMATION

Student's Name ______________________________ **Date of Birth** ______________

School ______________ **Grade** ______ **Teacher** ______________ **School Year** ______

List any known drug allergies/reactions ______________ **Height (inches)** ______ **Weight (lbs)** ______

PRESCRIBER AUTHORIZATION

Name of Medication ______________ **Reason for Taking** ______________

Dosage ______ **Route** ______________ **Frequency/Time(s) to be given** ______________

Begin Medication ______________ **Stop Medication** ______________

Date — **Date (automatically expires at end of school year)**

Special Instructions:

Does medication require refrigeration? Yes ☐ No ☐

Is the medication a controlled substance? Yes ☐ No ☐

Potential Side Effects/Contradictions/Adverse Reactions ______________

______________ ______________ ______________ ______________

Signature of Prescriber ***(please print)*** **Date** **Phone** **Fax**

PARENT AUTHORIZATION

I authorize the School Health Aide to delegate to other school personnel the task of assisting my child in taking the above medication and to communicate with other school personnel about the medication, action and possible side effects. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed. I also authorize the School Health Aide to talk with the prescriber or pharmacist should a question come up about the medication.

Medication must be registered with school staff. It must be in the original bottle/package and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration and the date of drug expiration when appropriate.

I release all school personnel and the Wheaton School district #803 from any and all liability in the event of any adverse reactions resulting from the use or administration of this medication.

______________ ______________ ______________ ______________

Signature of Parent **Date** **Phone** **Cell**

Wheaton Area Schools #803

AUTHORIZATION FOR NON-PRESCRIPTION MEDICATIONS

STUDENT INFORMATION

Student's Name ______________________________ Date of Birth ____________________

School ____________________ Grade ________ Teacher ____________________ School Year ______

List any known drug allergies/reactions ____________________ Height (inches)_ ______ Weight (lbs) _______

MEDICATION INFORMATION

Name of Medication ______________________________ Reason for Taking ____________________

Dosage ____________ Route ______________ Frequency/Time(s) to be given ____________________

Begin Medication ____________________ Stop Medication ____________________
Date   Date (automatically expires at end of school year)

Expiration Date of Medication ________________

Potential Side Effects/Contradictions/Adverse Reactions ______________________________

Student's Medical Provider ______________________________ Phone # ____________________

PARENT AUTHORIZATION

I authorize the School Health Aide to delegate to other school personnel the task of assisting my child in taking the above medication and to communicate with other school personnel about the medication, action and possible side effects. I also authorize the School Health Aide to talk with the prescriber or pharmacist should a question come up about the medication.

I will notify the school if the medication is discontinued or the dosage has been changed.

Medication must be registered with school staff. It must be in the original bottle/package and be clearly labeled with the student's name.
I release all school personnel and the Wheaton School district #803 from any and all liability in the event of any adverse reactions resulting from the use or administration of this medication.

______________________________ ______________ ________________ ________________
Signature of Parent Date Phone Cell

PLEASE NOTE:

A separate permission form is required for each medication to be given.

Parents are responsible for noting the expiration date of all medications. Expired medications will not be given at school.

Any medication not picked up by the last day of school will be destroyed.