Northwest Community Schools
Authorization for Administration of Medication

Name of Student:____ Date of Birth:_______________
Teacher:_____________________________ Grade:___________ Date form Received:_______________

Name of Medication:____
Reason for Medication:____
Dosage:________ Frequency:________ Time: ________ If PRN Specify frequency::________________
Medication Type: ▢ Daily ▢ Emergency ▢ As Needed
Form of Medication/Treatment: ▢ Tablet/Capsule ▢ Liquid ▢ Inhaler ▢ Injection ▢ Drops
▢ Nebulizer ▢ Topical ▢ Other:__________
Special Instructions:____
Relevant Side Effects: ▢ None Expected ▢ Specify:______________________________________
The Student is both capable and responsible for Self Carrying and Self Administering: ▢ YES ▢ NO

Prescriber Authorization
Prescriber's Name:__________________________________Phone:_____________ Fax:____________
Address:____
Prescriber's Signature:____

Parent/Guardian Permission
I am giving my permission for the prescriber listed above to release information to Northwest Community Schools. I hereby grant permission for school personnel to supervise the administration of the prescribed medication (listed above) for the above named student. I hereby release the Northwest Community Schools, its personnel from any liability in the administration of the medication listed above.

I approve of this medical information being shared amongst Northwest Community Schools personnel including teachers, classroom aides, principals, office staff, playground supervisors, food service staff, and bus drivers via email, verbal or written communication to provide the best possible care in an emergency.

- A separate authorization form must be completed for each medication.
- Medications must be delivered to the school by an adult in the original appropriately labeled container.
- This authorization is for the current school year only.
- Medication must be picked up within one week of the school year ending or it will be properly disposed of.

Parent/Guardian Signature:____Date:_________________

Self Carry/Self Administration of Medication Authorization/Approval
I am giving permission for my child, ____________________, to self administer and self possess the medication listed above. I hereby state that my child has the knowledge and ability to perform self administration of this medication, and not allow other persons access to his/her medication. If that occurs, my child and I understand that this privilege will be revoked.

Parent/Guardian Signature:____Date:________________
Student Signature:____Date:________________
School Nurse Approval:____Date:________________