# Webster Groves School District
# Authorization to Administer Medicine

School__________________

****Parent/guardian(s) will provide the school with medication in a prescription bottle or original container if medication is over-the-counter. No medication will be given without appropriate packaging/dosing instructions (no pills in baggies, etc.)**

Student____________________ DOB___________ Grade/Teacher______________

Name of Medication___________________ Dose_________ Time(s) Given_______________

Reason for Medication_________________________ Prescription_____ Over the Counter_____

Form of Medication: _____ tablet/capsule ____ inhaler ____ liquid _____ nebulizer ____ injection

Physician's Name_____________________ Phone Number___________ Fax Number _________

I request and authorize school personnel to give the above medication to the above student and to contact the physician directly if there are any concerns about the medication or the student's condition. I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication and to inform the school immediately if any information provided on this form changes, or if the administration of the medicine should stop. The school nurse will not be held liable for any effects as a result of giving the above medication.

Parent/Guardian Signature____________________________ Date___________

Best daytime phone number(s)_________________________ e-mail______________________

****Over-the counter medication may be given for one week with a parent/guardian's signature. If a medication is to be given for more than one week, a written order by a professional licensed to prescribe in the state of Missouri is required. See below**.

**Metered Dose Inhalers for students with asthma may be carried by students provided a licensed professional's order is received and the parent/guardian has signed a WGSD waiver.

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If you are providing an over-the-counter medication for more than one week, the following authorization must be provided by a professional licensed to prescribe.

## PHYSICIAN AUTHORIZATION

Name of patient ____________________________________________

Condition being treated_______________________________________

Medication ________________________________________________

Dosage and times___________________________________________

Possible side effects and/or comments____________________________

_________________________________________________________

Duration__________________________________________________

Physician Signature_________________________ Date_____________

*school fax_______________________ 01/08 msb