

Authorization for Administration of Medication

Name of Student:		Da [.]	te of Birth:	
Teacher:	Grade:	Date form	Received:	
Prescription Medication □ (Requires Ph	ysician Signature)	Non-Prescr	iption Medication □	
lame of Medication:		<u> </u>	4	
Reason for Medication:				
Oosage: Frequency:	Time: If F	PRN Specify free	luency::	
ledication Type: Daily Emerg	jency 🛛 As Needed			
orm of Medication/Treatment: □ Tab □ Nel	olet/Capsule □ Liquid bulizer □ Topical □ Ot		-	
Special Instructions:	·		•	
Relevant Side Effects: None Expe	cted Decify:			
For rescue inhalers and epinephrine au		nt is both capab	le and responsible for se	elf
arrying: • YES • NO Self admir	-	•	·	
Please note that a physician signatu	re is required for stu	dents to self ca	arry emergency medica	ition
Prescriber Authorization				
Prescriber's Name:		Phone:	Fax:	
Address:				
Prescriber's Signature:				
Further, I release Williamston Community Swhich may result to my child from the admirmy permission for the prescriber listed above approve of this medical information being verbal or written communication to provide A separate authorization form mus Medications must be delivered to the This authorization is for the current	nistration of said medicative to release information shared amongst Williams the best possible care in the best possible care in the school by an adult in the school year only.	tion as prescribed to Williamston Conston Community S an emergency. I medication. the original appro	by our physician. I am givir ommunity Schools. Schools personnel via email understand that:	ng
Self Carry/Self Administration of Med am giving permission for my child,	, to sas the knowledge and ab	elf administer and ility to perform sel	f administration of this	
ent/Guardian Signature:		[Date:	-
dent Signature:		ſ	Date:	