School District of Washburn
Prescription Medication Authorization Form
Note: each medication requires a separate form

Medication must be in original container*

Parent completes this section:

Students Name: _____ Address: _____

School: _____ Grade: _____ Teacher: _____ Birthdate: _____

Medication: _____ If a inhaler: ☐ Kept with student. ☐ Kept in health room

Name of pharmacy: _____ Phone number:_____ Allergies:_____

I hereby give permission for personnel designated by the principal or school nurse to give this medication to my child according to the directions stated. I also authorize school personnel designated in medication administration to contact my child's practitioner or me if there is a question regarding medication administration. I agree to notify the school when the drug is to be discontinued and/or the dosage or time is changed. I understand that if the medication is resumed, a new medication authorization form is required. I understand that any unused will be properly disposed of it not claimed after discontinuation of the medication. No medication will be sent home with students. I agree to hold the School District, its employees and agents, excluding health care professionals, who are acting within the scope of their duties, harmless in any and all claims arising from the administration of this medication at school.

Parent's Signature	**Date:**
Phone No.	**Work or Cell Phone**

Physician completes this section:

Physicians Name: _____ Office Phone: _____

Medication Name: _____ Purpose: _____ Dosage: _____ Form:_____

Time/circumstance medications should be administered: _____

If "as needed" indications_____ How soon can it be repeated_____

Prescription date:_____ Order date: _____ Discontinuation date: _____

Potential adverse reactions_____

I acknowledge by my signature that I will advise designated school personnel with regard to the administration of the medication described above, which includes accepting direct communication. I further acknowledge that all instructions should be stated in language of the lay person. I further understand that if the student is allowed to self-administer medication that proper instruction has been given.

Physician's Signature:	**Date:**
Clinic:	**Phone:** **Fax:**