



### Authorization for Administration of Medication

Name of Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Teacher: \_\_\_\_\_ Grade: \_\_\_\_\_ Date form Received: \_\_\_\_\_

Prescription Medication ☐ (Requires Physician Signature) Non-Prescription Medication ☐

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: \_\_\_\_\_

For rescue inhalers and epinephrine auto injectors: the student is both capable and responsible for self carrying: ☐ YES ☐ NO Self administering: ☐ YES ☐ NO

**Please note that a physician signature is required for students to self carry emergency medication.**

#### Prescriber Authorization

Prescriber's Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_

Prescriber's Signature: \_\_\_\_\_

#### Parent/Guardian Permission

I request that the child named above receive the medication/treatment at school according to standard school policy. I agree to immediately notify school personnel in writing in the event the prescription shall be discontinued or modified. Further, I release Williamston Community Schools and shall indemnify said school district from any liability or damage which may result to my child from the administration of said medication as prescribed by our physician. I am giving my permission for the prescriber listed above to release information to Williamston Community Schools.

I approve of this medical information being shared amongst Williamston Community Schools personnel via email, verbal or written communication to provide the best possible care in an emergency. I understand that:

- 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.

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 may be revoked.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_