WILMINGTON PUBLIC SCHOOLS
AUTHORIZATION FOR DISPENSING
MEDICATION

Please use one form for each Prescription or Over-the-Counter Medications that are to be administered in school.

A. TO BE COMPLETED BY PHYSICIAN:

I request that my patient receive the following medication:

Child's Name_____ Diagnosis_____

Name of Medication _____Date of Birth_____

Dosage and Route of Administration_____

Time(s) to be given _____ Duration _____

Possible Side Effects and Adverse Reactions_____

Other Recommendations_____

- ❑ Consent for self-administration (provided the school nurse determines it is safe and appropriate).

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Physician's Name (printed or typed) *Phone*

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Signature *Date*

B. TO BE COMPLETED BY PARENT:

I hereby authorize: _____
School Nurse Name

and/or a Substitute School Nurse as my agent to give the above medication to my child

_____as ordered by the Physician above for the following

time period _____.

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Signature of Parent/Guardian *Phone* *Date*

No medication will be accepted or administered by school personnel unless it is accompanied by a completed copy of this form. **All medications are to be furnished by the parent or guardian, in an appropriate container with a pharmacy &/or manufacturer's label.**