



Westfield Washington Schools Medication Authorization Form

Name of Student: _____ Birthdate: _____

Teacher: _____ Grade: _____

- Good for the current school year only.
- This form must be completed before giving medication at school. The school nurse can assist if needed.
- Medications that can be given before or after school hours should be given at home.
- Medications must be:
 - In the original container or if prescription in a bottle with the correct student's name and dosing information.
- Only 30 school days' supply of medication or remainder of days left of school if less than 30 will be stored in the clinic.
- Indiana State Law does not allow students to carry medications on them unless they have a physician authorization completed, see box below for provider signature.
- Discontinued or stopped medications should be picked up from the clinic within 1 week of notification.
- All medication must be picked up at the end of the school year; no medications (including EPI pens, inhalers) can be left in an unattended clinic over the summer months.
- Non-FDA approved medication will not be dispensed during school hours. This includes, but is not limited to, vitamins, essential oils and homeopathic medications.

I give permission for the school nurse and any trained staff caring for my child to administer this medication, contact my care provider regarding this authorization, if necessary, and for this form to be faxed/emailed to my child's school or be shared with school staff per FERPA guidelines. I assume full responsibility for providing the school with this medication.

Parent/Guardian Signature: _____ Date: _____

Printed Name: _____ Phone Number: _____

A physician signature is required if the medication given at school is a prescription medication, over the counter medication given outside of the manufacturer recommendations or is an emergency medication that requires authorization self carry.

Provider verification for self-carry and self-administer of emergency medications:

- 1) indicated for emergency administration to treat a disease/medical condition, **AND**
- 2) in your professional opinion as a health care provider, it would be appropriate for the student to carry and self-administer, **AND**
- 3) the child has received instruction on how and when to administer and is able to self administer.

By checking this box it is of my opinion as a provider, that the student meets the criteria above ☐

Name of Medication: _____ Dose: _____

Route: _____ Time to be given _____ Frequency _____

If PRN, list frequency and symptoms: _____

Medical Diagnosis: _____

Medication shall be administered from: _____ to _____ ☐ End of school year

***Prescriber's Signature:** _____

Date: _____

Prescribers Name/Title: _____

Telephone: _____

Fax: _____

Address/Office: _____

Student Name:

DOB:

Medication:

Medication Inventory Control

Date	Time	Qty On hand	Qty Signed In	Qty Signed Out	*Qty Destroyed	Total Clinic Inventory	Parent/Designee Signature	Nurse/VHA Signature

* All medication that is not picked up by the end of the school year will be disposed of per EPA guidelines.