



**WJCC Public Schools
Medication Authorization**

(Use a separate authorization form for each medication)

Part I Parent/Guardian Consent

School Year

I hereby request WJCC Public Schools personnel to administer medication as directed by this authorization. I agree to furnish said medication in the ORIGINAL container supplied by the pharmacy with the label intact. I understand the WJCC Public Schools Medication Administration Protocol and Policy and accept that the WJCC Public School Board, its employees, agents or designees are not responsible for any effects of the medication administration. By signing below, I authorize a representative of the school to share information regarding this medication with the licensed prescriber.

Student Last Name: _____ First Name: _____ M.I. _____

Teacher: _____ Grade: _____ DOB: _____

Check Where Appropriate:

- I request that the school nurse/designee send appropriate dose(s) of the prescribed medication on field trips to be given by my child's teacher or designee.
- My child has permission to carry/self-administer inhaled asthma medication. I have provided the school with appropriate documentation from my child's health care provider. See Form # H. S. 3-7
- My child has permission to carry/self-administer auto-injectable epinephrine. I have provided the school with appropriate documentation from my child's health care provider. See Form # H. S. 3-7

Parent/Guardian Signature

Daytime Phone

Date

Part II Prescriber Must Complete and Sign for all Medications

WJCC Public Schools discourage the use of medication by students in school during the school day. Any necessary medication that possibly can be taken before or after school should be so prescribed. School personnel will, when absolutely necessary, administer medication during the school day and while participating on field trips with parent permission.

Diagnosis: _____

Name of medication: _____ Dose: _____

Time(s) to be given at school per prescription (please check each that apply): Daily @ _____

PRN if morning dose is not given/taken at home and missed dose confirmed by parent

PRN for _____ every _____

Effective Date: Current School Year OR From _____ To _____

Allergies: _____

Prescriber Signature _____ **Name (Print)** _____

Telephone _____ **Fax** _____ **Date** _____