WARREN WOODS PUBLIC SCHOOLS
MEDICATION /PARENT AUTHORIZATION FORM

Student Name: _____ Birth Date: _____ Grade: _____ School Year: _____
School: _____ Date Form Received by School: _____

TO BE COMPLETED BY PHYSICIAN/LICENSED PRESCRIBER:

	Medication Name	Dose	Time To Be Given	Form/Route*	Side Effects	Adverse Reactions
1						
2						

*Routes-oral (pill/capsule/chewable, liquid) – inhaled (inhaler, nebulizer) – topical skin application – topical (eye drop, ointment)-topical ear drop-injection-other list

List minimal frequency between doses (especially if p.r.n/as needed.) _____

If p.r.n. (as needed), list symptoms/conditions under which medication is to be given: _____

Reason for medication (optional) *Medication #1* _____ *Medication #2* _____

Special Instructions: _____

START DATE: if not beginning of school year: _____ **STOP DATE:** if not end of school year: _____

□ I request that my child be assisted by authorized school personnel in taking the described medication at school according to Board of Education Policy #5330.

□ I request that my child be allowed to self-administer the above medication at school according to school policy.

□ I authorize school personnel to administer:
_____Glucagon _____ Epinephrine _____ Other _____
If based on their observation, they believe a life-threatening condition exists. I hereby release Warren Woods and its personnel from any and all liability that may result form their determination that a life threatening condition exists.

□ This student is capable and responsible for carrying and self administering
_____ Epi-Pen _____ Inhaler
(A second Epi-Pen or inhaler must be stored in the school office)

_____ _____ _____
Physician's Signature Date Physician's Printed Name

_____
Physician's Phone # Fax # Physician's Address

TO BE COMPLETED BY PARENT/GUARDIAN:

I request and give permission for (name of child) _____to receive the above medication(s)/treatment at school according to standard school district policy and for the physician ('s) staff and school district staff to share information needed to assist my child with medication needs. (Schools require parent/guardian to bring medication in its original container.)

- I will assume responsibility for safe delivery of the medication to school, either by me or by my child
- I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment
- I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

_____ _____
Parent/Guardian Signature Date

Revised 6/6/08