



## 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** \_\_\_\_\_