

West County R-IV Elementary School
Prescription Medication Authorization

To be completed by Parent/Guardian

Child's Name _____ Birthdate _____

Physician's Name _____ Phone _____

Medical History/Plan of Action in case of an emergency: _____

I request that my child be assisted in taking the medicine(s) described below at school by authorized persons or be permitted to medicate him/herself as also authorized by me and our physician. The school district shall incur no liability as a result of any injury arising from the student's self-administration of medication. The parent/guardians shall not hold the district and its employees or agents against any claims arising out of the student's self-administration or assistance with medication. I give district employees permission to contact the student's physician directly to provide information on the student's condition. I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication and for informing the school district immediately if any information provided on this form changes or if the administration of medication should cease.

Parent/Guardian Signature _____ Date _____

Home Phone _____ Emergency Phone _____

Please indicate any Additional Information:

Must be completed by Physician.

Diagnosis: _____

Name of medication _____ Dose _____

Form of medication/treatment (e.g. tablet, capsule, inhalor) _____

Special storage requirements: [] None [] Refrigerate

DAILY time to be given at school _____

If "As needed", Indicate Maximum Dosage per day: _____

Child is permitted to medicate him/herself? (circle) YES NO

List any side effects _____

Length of time for this medication (days or school year) _____

Physician's Name: _____ Phone _____

Address _____

Physician's *Signature* _____ Date _____

Note: We reserve the right to keep medications in the School Health Office to be dispensed as authorized.

*******ALL MEDICATION, PRESCRIPTION OR NON-PRESCRIPTION, MUST
BE IN ORIGINAL PACKAGE AND IDENTIFIED WITH STUDENT'S NAME.
A RESPONSIBLE ADULT MUST BRING MEDICINE TO SCHOOL.**