



AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

Dear Parent/Guardian and Physician:

We discourage the administration of medication in the school setting and request that whenever possible medications are scheduled during non-school hours. If medication is needed while in school, the following requirements must be met on the first day that the student is to receive medication:

1. No medication will be administered without the parents/guardian's signed consent and the physician's written medication authorization order. This will be kept on file in the Student's Cumulative file. The parent/guardian is responsible for obtaining the required information from the physician.
2. A separate Parent/Guardian Consent Form and Physician's Medication Authorization Order must be on file for each medication a student is to receive at school.
3. The medication must be properly labeled by the pharmacist. The label must include:
 - a. Student's name
 - b. Name of medication
 - c. Date
 - d. Dosage and time of administration
 - e. Directions for administration
4. The first day's dosage of any new medication must be given at home.
5. All medications must be brought to school by the parent/guardian and given to authorized personnel.
6. The parent/guardian is responsible for submitting to the school, in writing from the physician, notification of any change in dosage or time of administration.
7. All medication kept in school will be stored in a secure area accessible only to authorized administering personnel. (Such storage will be at the risk of the parent/guardian.) Watersprings School personnel will not assume any responsibility for possible loss of students' medication.
8. One week after expiration of the physician's order, the unused portion of the medication must be collected by the parent/guardian or it will be destroyed.
9. Watersprings School personnel will not assume any responsibility for non-medically prescribed medication or medication self-administered by the student.
10. Parents/guardians must let Watersprings School know in writing if a student is Lactose-intolerant.



AUTHORIZATION FOR MEDICATION ADMINISTRATION FORM

NAME OF STUDENT: _____ DOB: _____ Grade: _____

PART 1: PARENT/GUARDIAN CONSENT FORM

Parent/Guardian: *Please complete and sign.*

I hereby request and authorize Watersprings School to administer prescribed medication as directed by the physician.

I have read the procedures on the reverse side of this form and agree to assume the responsibilities as required. This medication is a new or renewal prescription. If new prescription, enter date and time the first dose was given at home.

Date: _____ Time: _____ A.M./P.M.

SIGNATURE OF PARENT/GUARDIAN _____ RELATIONSHIP _____

PLEASE PRINT NAME _____ DATE _____

PLEASE TAKE THIS FORM TO STUDENT'S PHYSICIAN FOR THE COMPLETION

PART II: PHYSICIAN'S MEDICATION AUTHORIZATION ORDER

Physician: *Please complete and sign.* Original Renewal Change

NAME OF STUDENT: _____ DOB: _____

ADDRESS: _____ Tel. No: _____

DIAGNOSIS: _____

NAME OF MEDICATION: _____

DOSE: _____

TIME CIRCUMSTANCES OF ADMINISTRATION AT SCHOOL: _____

EXPECTED DURATION OF ADMINISTRATION: _____

CAN REACTION BE EXPECTED? Yes No If yes, please describe: _____

If any change, please advise in writing immediately.

PHYSICIAN'S SIGNATURE _____ ADDRESS _____

PLEASE PRINT NAME _____ TELEPHONE NO. _____ DATE _____