WESTFIELD WASHINGTON SCHOOLS
Permission for Medication Administration
(Prescription and Non-prescription LIST ONLY ONE MEDIATION PER FORM)

Student Name: ____

Teacher:______________________________ **Grade:** __________

Name of Medication: ____________________ **Prescribing Physician**:____________________

Dosage: ______________ **Frequency**:________________ **RX No**. ________________

Time to be given: ____

Start Date ______________________ **Stop Date** ______________________

Do you want your student to receive this medication on early dismissal days? ○ **Yes** ○ **No**

Do you want your student to receive this medication on field trips? ○ **Yes** ○ **No**

Allergies to medications: ____

Westfield Washington Schools Medication Policy:

- ► All medication needed during school hours will be dispensed by the nurse, administrator, or designated school office staff.
- ► All medications, both prescription and non-prescription **must be in the original container**.
- ► No medication will be administered without the written consent of the parent/guardian
- ► This form is only good for the current school year for which it is signed.
- ► **To safeguard our students, all medication, both prescription and non-prescription must be brought into the nurse's office by a parent or guardian, or an adult appointed by the parent or guardian.**
- ► No student shall be permitted to carry medication on their person. Any exceptions to this rule will be made only with prior approval from the nurse and/or principal.
- ► Any unused medication which is unclaimed by the parent will be destroyed by school personnel when a prescription is no longer to be administered or at the end of the school year.
- ► No over the counter products that are not FDA approved will be dispensed during school hours. This includes vitamins, enzymes and homeopathic medication

I give permission to the school nurse to share with the prescribing physician information relative to this medication administration (i.e. effectiveness, adverse side effects) as she/he determines necessary for the health and safety of my child.

I authorize the school nurse or school personnel, under the supervision of the school nurse, to be my agent to give the following medication to my son/daughter:

______________________________ ______________________

Parent/Guardian Signature **Date**

Home phone: ______________________

Mother's work phone: ______________________

Father's work phone: ______________________

* Complete back of Form for Medication Inventory Control

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Date	Name of Medication	Dose to be given	# of Doses dropped off	Signature of School Staff	Signature of Parent	Location of Medication
						☐ Clinic Supply ☐ To Home ☐ Destroyed
						☐ Clinic Supply ☐ To Home ☐ Destroyed
						☐ Clinic Supply ☐ To Home ☐ Destroyed
						☐ Clinic Supply ☐ To Home ☐ Destroyed
						☐ Clinic Supply ☐ To Home ☐ Destroyed
						☐ Clinic Supply ☐ To Home ☐ Destroyed
						☐ Clinic Supply ☐ To Home ☐ Destroyed

Comments:____

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