Supervised and Emergency Medication Permission Form

Student:	Date of Birth:	Parent/Guardian:
Today's Date:		Home Phone:
School:	Bus:	Work Phone:
Grade: Teacher:		Cell Phone:

Use a separate form for each medication.

NOTE: All administration of medications must be in compliance with WCS board policies, especially 3260.

Name of Medication	Dosage/mg	Route (mouth, eyes, nose, etc.)	Times medication is to be given at school

Reason for medication ____ ADHD ____ Headache/Migraine ____ Fever/Pain ____ Asthma ____ Allergy

Side Effects/Precautions _____

START DATE _____ /_____ /_____ STOP DATE _____ /_____/_____

TO BE COMPLETED BY HEALTHCARE PROVIDER

☐ **Supervised Administration: School Staff will keep and give this medication for this student. All controlled, stimulant and/or narcotic medication must be given and supervised by school personnel for all students at all grade levels.**

☐ **Self-Administered Emergency Medication: Student has been instructed and is capable to keep/take this medication on his/her own based on the medical necessity.**

☐ **Student will not share this medication with anyone.**

☐ **All medication must be in a properly labeled pharmacy or store container.**

***Must be signed by Healthcare Provider**

*Healthcare Provider *Signature*_____

*Healthcare Provider (PRINT) _____ Date_____ Phone_____

TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN

I hereby give my permission for my child (named above) to receive this stated medication at school.

I assume full responsibility and will inform school staff of any medication changes or health status. I hereby release WCS Board, their agents and employees from any and all liability that may occur as a result of any medication administration. **I will provide a new medication form each school year and each time the dose/medication changes. I agree to furnish medication in an original, properly labeled pharmacy or store container. I will pick-up unused/ discontinued medication as needed during (or by end of) the school year.**

***Parent/Legal Guardian Signature** _____ **Date** _____

Daytime Phone Numbers _____

Bus Driver Notified ☐ YES ☐ NO ☐ N/A

☐ Student demonstrates adequate knowledge to keep, carry and take this medication.

School Nurse_____ Date _____

Reviewed at School by_____

School Nurse Date