Westfield Washington Schools Medication Authorization Form

Name of Student:_____ Birthdate:_____

Teacher:_____ Grade:_____

- This authorization is valid for the current school year only. Please complete one form for each medication.
- This form must be completed in full in order for the school to begin administering medication.
- Complete a new form for any changes to medication (time, dose, name, and frequency).
- All medication must be in the original container with the student's name and current dosing information on the label.
- Medication that can be given outside of school hours should be given at home; this allows time for the medication to take effect before the start of the school day and avoids missing class time.
- Non-FDA approved medication will not be dispensed during school hours. This includes, but is not limited to, vitamins, essential oils and homeopathic medications.
- School nurses can accept only 30 school days' supply of medication or remainder of days left of school if less than 30.
- Additional doses must be dropped off at school by the parents/guardian or a person appointed in writing by the parent/guardian. Medication can NOT be transported by students unless the physician has authorized to self-carry and self-administer.
- Discontinued or stopped medications should be picked up from the clinic within 1 week of notification. All medication must be picked up at the end of the school year; no medications (including EPI pens, inhalers) can be left in an unattended clinic over the summer months.

I give permission for the school nurse and any trained staff caring for my child to administer this medication, contact my care provider regarding this authorization, if necessary, and for this form to be faxed/emailed to my child's school or be shared with school staff per FERPA guidelines. I assume full responsibility for providing the school with this medication.

Parent/Guardian Signature:_____ Date:_____

Printed Name: _____ Phone Number:_____

School Day Physicians Medical Order (Completed Health Care provider)

A <u>physician signature</u> is required if the medication given at school is one or more of the following:

- A prescription medication
- An over the counter medication given outside of the manufacturer recommendations (dose, frequency, route)
- Permission to self-carry and self-administer at school for chronic medical conditions regarding emergency medication

Name of Medication:_____Dose:_____

Route: _____ Time to be given_____Frequency_____

If PRN, list frequency and symptoms:_____

Medical Diagnosis: _____

Medication shall be administered from:_____ to _____ ☐ End of school year

Permission to self-carry and self-administer: If this medication is: 1) indicated for emergency administration to treat a disease/medical condition, **AND** 2) in your professional opinion as a health care provider, it would be appropriate for the student to carry and self-administer, **AND** 3) the child has received instruction on how and when to administer: **check here** ☐

***Prescriber's Signature:**_____ Date:_____

Print Prescriber's Name/Title:_____

Telephone:_____ FAX:_____

Address: _____

Prescriber's Address Stamp

STUDENT NAME:_____ DOB_____ MEDICATION NAME:_____ DOSE:_____

Medication Inventory Control								
Date	**Time**	**Qty On hand**	**Qty Signed In**	**Qty Signed Out**	***Qty Destroyed**	**Total Clinic Inventory**	**Parent/Designee Signature**	**Nurse/VHA Signature**

* All medication that is not picked up by then end of the school year will be disposed of per EPA guidelines.