Willows Preparatory School

AUTHORIZATION FOR PRESCRIBED MEDICATION

Student's Name _____

Birthdate _____ Grade ____ Parent/Guardian Phone #_____

This section is to be completed by the LICENSED HEALTH CARE PROVIDER (please print):

Diagnosis or reason for medication _____

Medication	Dose	Route	Check if PRN	Time/Frequency or PRN Instructions

Significant side effects _____

Start Date_____ **End Date**_____ **or end of school year** ☐

If ordered and the School Dedicated Administrator is NOT AVAILABLE (e.g. field trip, after school activity etc.):

***Epinephrine Auto-injector WILL be given for ANY allergy symptoms or known ingestion.**

***Glucagon and Diastat WILL NOT be administered by other school staff and 911 will be called in case of emergency.**

LHCP Office Stamp

LHCP's Signature_____ Date_____

LHCP's Print Name_____

Phone Number _____ Fax Number _____

Email _____

This section to be completed by parent or guardian

- I request that my child be assisted by authorized personnel in taking the medication prescribed on the back of this form at school or be permitted to self-medicate according to Health Care Provider (HCP) instructions.
- I understand that my signature on this form constitutes a waiver by me to the school and authorized supervising personnel for liability for adverse reaction when medication is administered in the proper manner.
- **Changes to the time and/or dose of medication require written authorization from the HCP and Parent/guardian.**
- I understand that a medication dosage could be delayed or missed due to unexpected circumstances or changes in the student's schedule. If I am unable to accept this condition the district is not obligated to honor the request for administration of medication by school staff.
- **Medication must be provided to the school in a properly labeled prescription bottle or the original over-the-counter container. Ask the pharmacist to supply a second prescription bottle for school use.**
- I give permission for exchange of information between the school and HCP.

Parent/Guardian Signature _____ **Date** _____

❑ I request permission for my child to **self-carry medication for asthma or anaphylaxis during any school-sponsored activities occurring before/after school or overnight outdoor education programs.**

❑ I request permission for my child to **self-administer medication for asthma or anaphylaxis.** By law my signature indicates that I understand the district shall incur no liability as a result of any injury arising from the self-administration of medication by the student and parents or guardians shall hold harmless the district and its employees or agents against any claim arising out of the self-administration of medication by the student.

Parent/Guardian Signature_____ **Date** _____

Please return to: Willows Preparatory School