



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
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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 _____

