# Western Wayne School Corporation
# Authorization for Medication
## Parent Authorization

| ______________________________ | ______________________________ |
|---|---|
| **Students Name** | **Date of Birth/Grade/Teacher** |
| ______________________________ | ______________________________ |
| **Mailing Address** | **School** |

1. I am requesting permission for the above named student to receive the medication as prescribed by the physician and as directed below.
2. I will assume responsibility for safe delivery of the medication to school, either by me or by my child.
3. I understand the medication must be delivered in its original container and will not be given without this form complete and on file.
4. I will notify the school immediately of any changes in the use of the medication and provide documentation of these changes from the prescribing physician.
5. I release and agree to hold the Board of School Trustees, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.
6. I understand that medication not picked up at the end of the year will be discarded.

**DO YOU WANT MEDICATION TO BE GIVEN ON HALF DAYS:YES___ NO___**

| ______________________________ | ______________________________ |
|---|---|
| **Signature of Parent/Guardian** | **Date** |
| ______________________________ | ______________________________ |
| **Home Phone** | **Work Phone** |

## Physician Authorization

I have prescribed the following medication to be administered to the above named student:

Medication and dose:______________________________________________________

Medication to be given at what time at school:___________________________________

Special Instructions:_______________________________________________________

Possible side effects:______________________________________________________

| ______________________________ | ______________________________ |
|---|---|
| **Physician Signature** | **Date** |
| ______________________________ | ______________________________ |
| **Printed Physician Name** | **Office Number** |

**The School Nurse, Substitute Nurse, Principal, Assistant Principal, Secretary, and Counselor are trained and authorized to administer the above prescribed medications to the above named student.**

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**School Nurse**