Fax 269.503.8877 www.waylandunion.org

WAYLAND UNION SCHOOLS
HOME OF THE WILDCATS

ADMINISTRATION OF MEDICATION FORM

Medication (both prescription and over the counter) may be administered at school by school personnel when necessary for school attendance. This completed form, along with the medication and/or special equipment items are to be brought to the school by the parent/guardian.

As a parent, I understand my responsibilities are:

1. ***To provide the school with a supply of medication in the original container, appropriately labeled by the pharmacy. (Parents may request that the pharmacist dispense two bottles of medication, one for home and one for school.***
2. ***To provide the school with the written doctor's instructions for medication administration during school hours.***
3. ***To inform the school of any medication and/or medical changes.***

Medication means: "any prescription or over the counter medication. This includes, but is not limited to, vitamins and food supplements; eye, ear, and nose drops; inhalants; medicated ointments or lotions; aspirins; cough drops; antacids." Please refer to Board Policy 5330 for further details.

Student: _____ Date of Birth: _____/_____/_____ School Year:_____

Parent/Guardian Name: _____ Phone Number: (_____) _____

I hereby request that the building administrator or their designee, administer the (prescribed) medication/procedure listed below, as directed.

Name of Medication: _____

◯ Tablet/Capsule ◯ Liquid ◯ Inhaler ◯ Injection ◯ Nebulizer ◯ Other

Dosage: _____ Time to be Taken at school: _____

This also authorizes an exchange of information, as necessary, between the school and my child's healthcare provider.

Signature of Parent/Guardian: _____ Date: _____

Signature of Student, if 18 or older: _____ Date: _____

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To be completed by a Physician, *for prescribed medication only.*

Physician's Name (print): _____

Physician's Office Address: _____

Reason/Condition for Medication: _____

Name of Medication: _____

◯ Tablet/Capsule ◯ Liquid ◯ Inhaler ◯ Injection ◯ Nebulizer ◯ Other

Dosage: _____ Time taken during school: _____

Restrictions and/or side effects ◯ None anticipated ◯ Yes, please describe below:

_____

Storage Requirements ◯ None ◯ Refrigerate ◯ Other

This student is both capable and responsible for self-administering this medication (for inhaler, emergency medication or FDA approved topical only):
◯ No ◯ Yes

**Additional information: ◯ Attached ◯ On back of form

Physician's Signature: _____ Date: _____

Office Phone: _____ Office Fax: _____

A copy of this form will be kept in the office/health room and will be renewed annually or whenever the prescription changes within the current school year.