PRESCRIPTION MEDICATION/TREATMENT AUTHORIZATION FORM
2023-2024 School Year

Name of Student_____ Birthdate_____ Grade_____

TO BE COMPLETED BY PHYSICIAN OR LICENSED HEALTHCARE PROVIDER: (please do not use abbreviations)

Diagnosis/purpose of medication/treatment (optional)_____

Name of medication/treatment_____

Dosage_____ Frequency_____ Time_____ Route_____

Start date_____ Stop date_____ Instructions, adverse reactions, storage requirements, etc.

_____

(If more space is needed, attach additional sheet)

SELF-ADMINISTRATION RECOMMENDATION: (please check one)

____ This student is capable of carrying this medication and administering it unsupervised – (**Grades 7-8 only**)

____ This student may carry this medication and self-administer it under staff supervision (this applies to emergency medications such as inhalers, insulin, etc. – **Grades K- 8**)

____ No student self-administration

Physician's Signature:_____**Date**_____

Printed Name_____**Phone**_____

Address_____

TO BE COMPLETED BY PARENT/GUARDIAN:

TO BE SIGNED BY PARENT/GUARDIAN:
I understand and agree with my physician's administration recommendation.

Parent Signature_____ Date_____

- I have reviewed the Woodland School policy regarding administration of medication to students and agree to abide by the terms.
- The prescription renewal and medication/treatment supply shall be the parent/guardian responsibility. **Medication must be delivered to the school office by parent or guardian.**
- All medications should be kept in a labeled container as prepared by a pharmacy, physician, or pharmaceutical company and clearly labeled with the student's name, dosage and frequency. This information MUST match the information on this form.
- No dosage or time of administration changes will occur except by **written** instruction from the physician and parental approval.
- I request that the medication/treatment be administered within the physician's/licensed healthcare provider's directions and according to the school's policy.
- The student is responsible for presenting himself/herself on time and for taking the medication as prescribed.

The undersigned releases the Woodland School from any liability or damage which may result to the student from the administration of said medication as prescribed by the physician.

Parent(s)/Guardian(s) Signature_____ **Date**_____

Printed Name_____