Wyoming City Schools

MEDICATION AUTHORIZATION FORM

STUDENT INFORMATION

Student Name: Grade: DOB: Building:

Address:

Parent/Guardian Name: Phone:

List any known drug allergies/reactions:

The prescribing provider and the parent/guardian must complete and sign this form before any medication, including over-the-counter, can be administered to the student.

OVER-THE-COUNTER MEDICATIONS

PARENT/GUARDIAN TO COMPLETE		PRESCRIBER TO COMPLETE	
MEDICATION	MAY GIVE	DOSAGE	TIME/INTERVAL
Acetaminophen (Tylenol)	☐		
Ibuprofen (Advil)	☐		
Anti-itch cream (Hydrocortisone) or lotion	☐		
Cough drops	☐		
Antacid (Tums)	☐		
Other:_____	☐		

PRESCRIPTION MEDICATIONS - Prescriber to complete

Medication:	Medication:	Medication:
Dosage:	Dosage:	Dosage:
Time/Interval:	Time/Interval:	Time/Interval:
Severe reactions to report to clinician:	Severe reactions to report to clinician:	Severe reactions to report to clinician:

Epinephrine Injector: ☐ Not applicable ☐ Yes, as the prescriber, I have determined that this student is capable of possessing and using an autoinjector appropriately and have provided the student with training in the proper use of the autoinjector.

Asthma Inhaler: ☐ Not applicable ☐ Yes, as the prescriber, I have determined that this student is capable of possessing and using an asthma inhaler appropriately and have provided the student with training in the proper use of the inhaler.

PRESCRIBER SIGNATURE: Date:

Prescriber Name (print): Phone: Fax:

PARENT/GUARDIAN PERMISSION

☑ I authorize an employee of the school board to administer the above medication(s).

☑ I understand that additional parent/prescriber signed statements will be necessary if the dosage of the medication changes.

☑ Permission to administer medication(s) above is only valid through the end of the current school year unless otherwise noted.

☑ Medication must be in the **original** container and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration, and the date of drug expiration when appropriate.

☐ ***If applicable:*** **Epinephrine Autoinjector:** I authorize my child to possess and use an epinephrine autoinjector, as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant. I understand that a school employee will immediately request assistance from an emergency medical service provider if this medication is administered. I will provide a backup dose of the medication to the school principal or nurse as required by law.

☐ ***If applicable:*** **Asthma Inhaler:** I authorize my child to possess and use an asthma inhaler as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant.

Parent/Guardian Signature: **Date:**

Completed forms may be hand-delivered to your child's school, uploaded to Final Forms, sent via email or fax to:

- Medication will not be administered without a medication authorization form signed by the prescriber and parent/guardian.
- All medication must be delivered to school by parent/guardian. Please do not send medication to school with your child.
- Controlled substances will be counted and verified by parent/guardian and designated school staff member.

Elm:	jonese@wyomingcityschools.org	(f): 513-206-7337
Hilltop:	vilardok@wyomingcityschools.org	(f): 513-206-7305
Vermont	grayt@wyomingcityschools.org	(f): 513-206-7305
Middle School:	joneske@wyomingcityschools.org	(f): 513-206-7245
High School:	murphyn@wyomingcityschools.org	(f): 513-206-7132