WA Prescription Medication Permission Form

School Year 2023-2024

Student_____DOB_____Grade_____

Policy for students receiving medication at school (whether prescribed medication by a physician or authorized prescriber or over the counter medication) is as follows:

- Signed orders from the parent/guardian and physician must be on file
- Over-the-counter medication brought in the original container
- Prescribed medication with a pharmacy label that matches the written orders
- ALL medication must be brought to the school by the parent
- School personnel may refuse to give the medication

To be completed by the Physician or Authorized Prescriber:

Reason for the medication: _____Name and strength of medication: _____

Form of medication: • Tablet/Capsule • Liquid • Inhaler • Injection • Other

Amount and Time/s: _____

For PRN: State the frequency, the time between dosages of medication, and maximum number of doses in a school day:

_____

Additional information: Instructions, restrictions and/or important side effects:_____

Start date for medication: _____End date for medication: _____ (All orders will be valid for the current school year)

Physician/Authorized Prescriber Signature _____Print Name_____

Date:_____ Phone Number _____ Fax_____

To be completed by the Parent/ Guardian: I instruct the school's headmaster/ the headmaster's authorized personnel to give the medication as instructed above.

- Do you want to be called before a PRN medication is given? Yes_____ No_____
- Additional information/instructions or restrictions _____

_____

Consent:

I hereby request that the medication specified above be given to the above named student. I understand that the school personnel who give the medication may not be a medically trained person. I realize that the school does not have to agree to allow medication to be given to a student by school personnel. I understand that the school's agreeing to allow the medication to be given is for my benefit and the student's benefit. Such agreement by the school is adequate consideration of my agreements contained herein. In consideration for the school agreeing to allow the medication to be given to the student as requested herein, I agree to indemnify and hold harmless Western Academy, its servants, agents, and employees including, but not limited to the school, the Headmaster, and the individuals giving the medication of and from any and all claims, demands, or causes of action arising out of or in any way connected with the giving of the medication or failing to give the medication to the student. Further, for said consideration, I, on behalf of myself and the other parent of the student, hereby release and waive any and all claims, demands, or causes of action against Western Academy.

Parent/ Guardian Signature _____Date_____

Print Name_____ Relation to the Student _____

Note: Special forms are required for Severe Allergies and Administration of Epipens, Administration of Diabetic Medication, and Self-administration of Medicine, and carrying of Asthma Medication.