

School Medication Permission

Student's Name _____ Grade _____ Teacher _____

Physician Order must be completed by student's physician for any prescription medication.

Name of Medication _____

Dosage _____ Frequency _____

Student's Diagnosis _____

Possible side effect(s) to medication _____

Other medication(s) student is receiving _____

Is it necessary that this medication be administered in school? Yes No

Physician's Signature

Date

Physician's Phone Number

Administration of medication by Wheaton Christian Grammar School personnel is contingent upon the following guidelines:

1. The physician's statement above must be completed.
2. We do not have a full-time nurse at WCGS. Medicine will be administered by a school secretary, non-medical personnel.
3. The medication must be brought to the school office in a pharmaceutical container labeled with the student's name, name of medication, the dosage and all pertinent instructions.
4. The school must maintain a written record of any medication dispensed. Such record must list student's name, name of medication, time it was administered, and by whom.
5. This form is valid for one school year only. Forms must be renewed each year, with parent and physician signatures.
6. Any change in prescription of this medication requires a new *School Medication Permission* form, complete with parent/guardian and physician signatures.

Parent Authorization for Administration of Medication in School

I hereby confirm that I have reviewed and understand Wheaton Christian Grammar School's policy regarding the administration of medication in school. I authorize Wheaton Christian Grammar School and its employees in my behalf to administer or attempt to administer to my child lawfully prescribed medication in the manner described on the Physician's Order for administration of medication in school above. In addition, I agree to hold harmless and indemnify the School and its employees from and against any and all claims, damages, and causes of action or injuries incurred or resulting from the administration or attempt to administer said medication.

Parent/Guardian Signature

Date