Wayland Public Schools
Parent/Guardian Authorization for Administration of Prescription Medication

Student's name: _____ DOB:_____

My student requires the following medications to be administered AT SCHOOL:

Medication: _____Dose:_____Time:_____

Medication: _____Dose:_____Time:_____

Medication: _____Dose:_____Time:_____

I consent to have the school nurse or school personnel designated by the School Nurse administer the medication listed above: _____Yes _____No

I give permission to the School Nurse to share information relevant to the prescribed medication administration to other school personnel as he/she determines appropriate for my student's health and safety. _____Yes _____No

My student is currently receiving the following additional medications (to be completed if not in violation of confidentiality):

_____

My student has the following food or drug allergies:_____

I understand I may retrieve the medication from the school at any time; however, the medication will be destroyed if it is not picked up within one week following termination of the order or at the end of the school year.

Parent/Guardian printed name_____

Parent/guardian signature_____Date_____

Best daytime phone number _____

Alternate person to be **notified in case of medication emergency**:

Name:_____ Phone number:_____

Relationship to student _____