WONDERSTEAD

A BIRMINGHAM MICROSCHOOL

Medication Authorization Form

School Year: _____

Student Name:

Date of Birth: _____ Age: _____ Grade: _____

Teacher: _____

Known Drug Allergies (write "none" if none): Weight (lbs): _____

_____

Medication 1:

Dosage:: _____

Route: _____ Frequency / Time(s) Given: _____

Start Date: _____ Stop Date: _____

Reason for Taking Medication: _____

Possible Side Effects / Contraindications: _____

Action to Take if Adverse Reaction Occurs: _____

Is this medication a controlled substance? ☐ Yes ☐ No

Is self-administration approved for this student? ☐ Yes ☐ No

Should this medication be kept on the student's person? ☐ Yes ☐ No

Emergency drug required during school transportation on excursions? ☐ Yes ☐ No

Additional Notes:

Medication 2:

Dosage:: _____

Route: _____ Frequency / Time(s) Given: _____

Start Date: _____ Stop Date: _____

Reason for Taking Medication: _____

Possible Side Effects / Contraindications: _____

Action to Take if Adverse Reaction Occurs: _____

Is this medication a controlled substance? ☐ Yes ☐ No
Is self-administration approved for this student? ☐ Yes ☐ No
Should this medication be kept on the student's person? ☐ Yes ☐ No
Emergency drug required during school transportation on excursions? ☐ Yes ☐ No
Additional Notes:

Medication 3:

Dosage:: _____

Route: _____ Frequency / Time(s) Given: _____

Start Date: _____ Stop Date: _____

Reason for Taking Medication: _____

Possible Side Effects / Contraindications: _____

Action to Take if Adverse Reaction Occurs: _____

Is this medication a controlled substance? ☐ Yes ☐ No
Is self-administration approved for this student? ☐ Yes ☐ No
Should this medication be kept on the student's person? ☐ Yes ☐ No
Emergency drug required during school transportation on excursions? ☐ Yes ☐ No
Additional Notes:

Medication 4:

Dosage:: _____

Route: _____ Frequency / Time(s) Given: _____

Start Date: _____ Stop Date: _____

Reason for Taking Medication: _____

Possible Side Effects / Contraindications: _____

Action to Take if Adverse Reaction Occurs: _____

Is this medication a controlled substance? ☐ Yes ☐ No

Is self-administration approved for this student? ☐ Yes ☐ No

Should this medication be kept on the student's person? ☐ Yes ☐ No

Emergency drug required during school transportation on excursions? ☐ Yes ☐ No

Additional Notes:

If your student requires additional medications, please attach instructions to this form for all medications.

Parent/Guardian Signature:

I authorize your child's teacher, or another trained staff member designated by the school, to administer or assist my child in taking the medication(s) listed above. Prescription medication must be in its original, labeled container; over-the-counter medication must be in its original, sealed container.

Date: _____

Self-Administration Authorization Signature:

I authorize self-medication by my child and confirm he/she has been instructed by the prescriber on proper self-administration. I will hold the school and its staff harmless for claims related to my child's self-administration of the medication(s) listed above.

Date: _____