WCS Westside Christian School

Appendix B - Medication Form

24/25 Medication Administration Form

Name of Student: _____ Grade: _____
Medication: _____ Dosage: _____ Route: _____
Medication must be taken at the following time(s): _____
Other specific instructions for administration: _____
Treatment in case of adverse reactions: _____
Beginning date: _____ Ending date: _____ Require refrigeration? ____ Yes ____ No

As the student's parent or guardian, I agree to the statements below:

1. I understand this request must be signed by both the physician (if prescribed medicine) and parent before administration of the medication will begin.
2. I will assume responsibility for the safe delivery of the medication to the school in the **original container** (as labeled by the pharmacy if prescription) and will assure an adequate supply of the medication has been provided to the school.
3. I agree to submit another form if there is any change in medication, dosage, and/or time medication is to be given.
4. I acknowledge that school personnel are under no obligation to administer the above drug and that such assistance may be rendered by a school employee who is not medically trained.
5. I release and agree to hold Westside Christian School, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

_____ _____ _____

Parent/Guardian Name Signature Date

REQUIRED FOR PRESCRIPTION MEDICATION ONLY AND TO BE COMPLETED BY A PRESCRIBER

Epinephrine Autoinjector? _____ No _____ Yes, as the prescriber I have determined that this student is capable of possessing and using this autoinjector appropriately and have provided the student with training in the proper use of the autoinjector.

Asthma Inhaler? _____ No _____ Yes, if conditions are satisfied per ORC 3317.716, the student may possess and use the inhaler at school or any activity event or program sponsored by or in which Westside Christian School is a participant. *I agree the information listed on this form is accurate and this student is under my care.*

_____ _____ _____

Prescriber Name Signature Date

MEDICATION CONSENT FORM

Over-the-Counter Medication

Please complete this form and return it to the office, in a ***zip lock bag*** with any medication that your child may need during the school day. THIS CONSENT DOES NOT INCLUDE PRESCRIPTION MEDICATIONS OR DIRECTIONS THAT DIFFER FROM THOSE WRITTEN ON THE ORIGINAL CONTAINER.

Student Name: _____ Age_____ Grade_____

Name of Medication: _____

Dosage: _____ Frequency: _____

Reason for medication: _____

Effective dates: from _____ to _____(or end of school year, whichever is sooner)

I give my consent for WCS staff to dispense the above medication (s) to my child.

_____ _____

Parent Signature Date

Please list below any further instructions. Please send the medication to school in the **original** container.