Webb City R-7 Health Services

AUTHORIZATION FOR MEDICATION ADMINISTRATION
PHYSICIAN CONSENT FORM

To Parents/Guardians:

We can not keep medication at school without permission from the physician. Please have this form completed and returned immediately. This includes over-the-counter medication as well as prescription. <u>All medication must be in original container</u>. Your pharmacist will label an extra prescription bottle for school. An adult may bring a one months supply to school. We will send home the empty bottle the day we give the last pill. If your child must transport the medication, do not send more than a weeks supply at a time. Thank you for your help.

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Student's name_________________________________Grade_____School________________
Parent's name____________________________Physician's name________________________

<u>PRESCRIPTION DRUGS</u>
Name of medication____________________________ Specific Dose_______________(mg. etc)

Specific time to be given at school____

Diagnosis for which medicine is given____

Date to begin ________________________ Date to end ________________________

Significant side effects____

Emergency Instructions (if applicable)____
____

____ _______________ Physician/Prescriber
Signature Date

<u>NON PRESCRIPTION DRUGS</u>

Name of Medication____

Purpose of Medication (be specific)
____

Or check those that apply:
_______headache minor pain :______________________
_______menstrual cramps other – specify: __________________________________

Dose and time:____

Date to begin: _______________________ Date to end:__________________

________________________________ ________________________
Physician/Prescriber Signature Date

Webb City R-7 Schools will not be responsible for unsupervised self-administered medications.
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