MEDICATION PERMISSION FORM

(One form for each medication)

I hereby certify that it is necessary for _____
(Full Name of Student – List name used by student)

Date of Birth: _____

Teacher: _____ Grade Level: _____ to be given the medication listed below during the school day, including when he/she is away from school property on official school business. Without this medication, he/she will not be able to attend school. Signed form is necessary for all the following: medicines given by mouth, inhaled, by nebulizer, on skin, patch, injection, etc.) Only FDA-approved medicines will be accepted.

Name of Medication: _____

Side Effects: _____

Reason for Medication (Diagnosis): _____

Exp. Date: _____ Dosage to be given:_____

Route (mouth, injection, etc.):_____ Allergies: _____

Time(s) of administration: _____ Beginning Date: _____ Ending Date: _____

Amount of Liquid or count of Pills: _____

Emergency Telephone Numbers:

Parent/Guardian: _____ H:_____ W:_____ C:_____

Parent/Guardian: _____ H:_____ W:_____ C:_____

Doctor's Name: _____ Phone:_____

Prescription and non-prescription medication shall come in the original container and shall be labeled. Changes in the medication times or dosage can only be made by written prescription from the physician, which may be faxed to the school. This permission form is valid for the current school year only. Parents are requested to pick up any leftover medication within ONE WEEK after the ending date. Medication left after this time will be discarded. I hereby consent to protected health information being used and disclosed to carry out treatment, payment, or health care operations of my child. I understand that Wakulla Christian School (WCS) may need to give and receive protected health information pertaining to the management of my child's medical condition with the health care provider listed above, and I hereby authorize the exchange of this information as needed to carry out the treatment, payment or health care operations of my child. I also give permission for the information on this form to be reviewed and utilized by the staff of WCS. I hereby authorize WCS, and its employees to assist my child with medication administration and/or to supervise my child's self-administration of medication(s) as directed by his or her prescribing physician(s). I hereby release, indemnify, and hold harmless WCS and its employees of any and all lawsuits, claims, demands, expenses, and actions against them associated with their activities assisting my child with medication administration and/or supervising my child's self-administration of medication(s), provided they follow the physician's orders on record. I also hereby agree to indemnify and hold WCS and their employees harmless from any and all lawsuits, claims, demands, expenses, and actions against them arising from harm to any person caused by my child's actions with regards to a self-carried medication.

_____

(Date) (Parent/Guardian Signature)

Original for School / Copy for Teacher

1391 Crawfordville Highway, Crawfordville, Florida 32327
Telephone: (850) 926-5583 • Fax: (850) 926-5186 • www.wakullachristian.com

For Office Use Only

Student: _____ School Year: _____

Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
1	1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4	4	4
5	5	5	5	5	5	5	5	5	5
6	6	6	6	6	6	6	6	6	6
7	7	7	7	7	7	7	7	7	7
8	8	8	8	8	8	8	8	8	8
9	9	9	9	9	9	9	9	9	9
10	10	10	10	10	10	10	10	10	10
11	11	11	11	11	11	11	11	11	11
12	12	12	12	12	12	12	12	12	12
13	13	13	13	13	13	13	13	13	13
14	14	14	14	14	14	14	14	14	14
15	15	15	15	15	15	15	15	15	15
16	16	16	16	16	16	16	16	16	16
17	17	17	17	17	17	17	17	17	17
18	18	18	18	18	18	18	18	18	18
19	19	19	19	19	19	19	19	19	19
20	20	20	20	20	20	20	20	20	20
21	21	21	21	21	21	21	21	21	21
22	22	22	22	22	22	22	22	22	22
23	23	23	23	23	23	23	23	23	23
24	24	24	24	24	24	24	24	24	24
25	25	25	25	25	25	25	25	25	25
26	26	26	26	26	26	26	26	26	26
27	27	27	27	27	27	27	27	27	27
28	28	28	28	28	28	28	28	28	28
29	29	29	29	29	29	29	29	29	29
30	30	30	30	30	30		30	30	30
31		31		31	31		31		31

Please place time and initials in appropriate box when medicine is administered.

This is to be kept in the office at all times. If this medicine is *required* to be kept near the child, please inform the office and maintain this chart. Turn form into the school office at the end of the school year. Thank you!