WAUKEE COMMUNITY SCHOOL DISTRICT
PERMISSION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

It is the policy of the Waukee Community School District that whenever a student should have a prescription medication or over-the-counter medication administered by school staff, written authorization and instruction must be provided by a parent or legal guardian.

All over-the-counter medication **MUST** be in the original container. Prescription medication **MUST** be in a properly labeled container issued by a registered pharmacist with the following information:
1. Name of medication
2. Dosage
3. Time medication is to be given at school
4. Name of student
5. Prescribing physician

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Name___________________________________________________________           Birthdate_________________

Teacher (elementary only) __________________________________        Grade ___________

*Medication______________________________________  *Dosage ___________  *Time _________________
  *Start Date _______________    *Stop Date _______________ or End of school year

*Medication______________________________________  *Dosage ___________  *Time _________________
  *Start Date _______________    *Stop Date _______________ or End of school year

*Medication______________________________________  *Dosage ___________  *Time _________________
  *Start Date _______________    *Stop Date _______________ or End of school year

Allergy to Medication/s   (circle one)         No               Yes  _______________________________________________

Special instructions?  (use back of form if necessary)
_____________________________________________________________________________________________

When medication complete or at the end of the school year:
_____ Send medication home with student
_____ Parent will pick medication up
_____ Dispose of medication

Parent/Guardian Signature ____________________________________________________  Date______________

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Prescription Medication count:

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Nurse/Medication Administrator
Signature/Title_________________________  Initials
Signature/Title_________________________  Initials

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Notes

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Nurse/Medication Administrator
Signature/Title _______________________________ Initials ____________________
Signature/Title _______________________________ Initials ____________________