Western Montgomery Career & Technology Center

MEDICATION ADMINISTRATION AUTHORIZATION

Student Full Name _____ Grade: ☐10 ☐11 ☐12

Date of Birth: _____ Allergies: _____

Name of Prescribed Medication: _____

Reason: _____ Dose: _____

Route: _____ Time to be given at school: _____

Medication is to be administered:

- ☐ Until completed Date of completion: _____
- ☐ Entire school year
- ☐ Daily
- ☐ As needed

_____ _____

Physician Signature Print Physician Name

_____ _____

Date Physician Phone

I, the parent/guardian of _____, request that the nurse of the Western Montgomery Career & Technology Center administer the above names medication as prescribed by my child's physician. My signature on this document constitutes a complete waiver of liability claim in any and all respects against the Western Montgomery Career & Technology Center and its Board of Directors and all its employees unless the District is negligent with regard to any claim for injury in connection with dispensation of the prescribed medication.

Additionally**, I agree to provide the medication to the school in the original pharmacy or physician labeled container**. If I am unable to deliver it, I will place it in a sealed envelope for transport to school and **delivered promptly to the nurse's office**. I also accept responsibility to provide a physician's note and my written instructions if the medication is to be changed or discontinued. I give permission for the school and physician to communicate regarding this medication/medical condition.

_____ _____

Date Signature of Parent/Guardian

List all medication currently being taken by your child: