

**Westminster School Medication Prescriber/Parent Authorization Form**

**Student Information**

Student's Name: \_\_\_\_\_

List any known drug allergies/reactions: \_\_\_\_\_

**Prescriber Authorization**

Name of Medication: \_\_\_\_\_ Reason for taking: \_\_\_\_\_

Dosage: \_\_\_\_\_ Frequency/Time(s) to be given: \_\_\_\_\_

Date to Begin Medication: \_\_\_\_\_ Date to End Medication: \_\_\_\_\_

Special instructions:

Does the medication require refrigeration?  Yes  No

Is the medication a controlled substance?  Yes  No

Is self-medication permitted and recommended for this student?  Yes  No

If asthma inhaler or emergency medication, where do you recommend this medication be kept?  
 On person  In Classroom  School office

Potential Side Effects/Contraindications/Adverse Reactions: \_\_\_\_\_

Treatment Order in the event of an adverse reaction: (Attach additional sheet or use the back of this form if necessary.)

\_\_\_\_\_  
Signature of Prescriber

\_\_\_\_\_  
Date

\_\_\_\_\_  
Phone

**Parent Authorization**

I am providing the above medication for my child. I understand that the Westminster office will call prior to administering the above medication. I understand that Westminster does not have a registered nurse or licensed practical nurse on staff. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed.

Medication must be in the original container and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, and the date of drug's expiration when appropriate.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Phone