**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