

School Medication Permission

Student's Name _____

Year 9 10 11 12

Physician Statement: (Changes in dosage require written authorization)

Name of Medication _____	
Dosage _____	Frequency _____
Student's Diagnosis _____	
Possible side effect(s) _____	
Other medications(s) student is receiving _____	
Is it necessary that this medication be administered in school? Yes No	
_____ Physician Signature	_____ Date
_____ Physician Phone Number	

Administration of medication by Wheaton Academy personnel is contingent upon the following guidelines:

1. The physician's statement above must be completed.
2. The medication must be brought to the school office in a pharmaceutical container labeled with the student's name, name of the medication, the dosage and all pertinent instructions.
3. The school must store the medication in a locked cabinet.
4. The school must maintain a written record of any medication dispensed. Such record must list student's name, name of medication, time it was administered and by whom.
5. The student's parent or guardian must renew written orders for continuing medication at the beginning of each school year, and whenever the medication or its dosage is changed.

Parent Authorization for Administration of Medication in School

(To be completed by Parent or Guardian)

I hereby confirm that I have reviewed and understand Wheaton Academy's policy regarding the administration of medication in school. I hereby authorize Wheaton Academy and its employees in my behalf to administer or attempt to administer to my child lawfully prescribed medication in the manner described on the Physician's Order for administration of medication in school above. I understand that it may be necessary for an individual other than a nurse administer medications to my child and I specifically consent to such practices. I further acknowledge and agree that when the lawfully prescribed medication is so administered or attempted to be administered, I waive any claims I might have against Wheaton Academy and its employees arising out of the administration of said medication.

Parent/Guardian Signature

Date