

WHITTIER REGIONAL VOCATIONAL TECHNICAL HIGH SCHOOL
AUTHORIZATION TO ADMINISTER PRESCRIPTION MEDICATION IN SCHOOL

Student's name: _____ Date of Birth: _____

Address: _____ Grade: _____

Name of Licensed Prescriber: _____ Title: _____

Office phone #: _____ Fax #: _____

Diagnosis: _____

Medication: _____

Route of Administration: _____ Dosage: _____

Frequency: _____ Time(s) of Administration: _____
(Please note: *Whenever possible, medication should be scheduled at times other than school hours*)

Possible side effects, contraindications, or possible adverse reactions to be observed: _____

Specific directions/info for administration: _____

Date of order: _____ Discontinue Date: _____

Consent for self administration of inhalers YES _____ NO _____

Signature of Licensed Prescriber

Date

PARENT / GUARDIAN PERMISSION

I consent to have the School Nurse administer medication to my son/daughter prescribed by the above Licensed Prescriber.

I give permission to the School Nurse to share information relevant to the prescribed medication administration as she determines appropriate for my son's /daughter's health and safety.

I understand I may retrieve the medication from the school at any time; *however, the medication will be destroyed if it is not picked up within one week following termination of the order or one week beyond the close of school.*

Parent / Guardian signature: _____ Date: _____