

## Supervised and Emergency Medication Permission Form

Student:	Date of Birth:			Parent/Guardian:		
Today's Date:				Home Phone:		
School:	Bus:			Work Phone:		
Grade: Teacher	:		Cell	Phone:		
Use a separate form f		cation.	•			
NOTE: All administrat	ion of medicat	tions must be in co	ompliance with	WCS board	policies, espe	cially 3260.
Name of Medication	Dosage/mg	Route (mouth, eye	_	_		be given at school
Reason for medication _	ADHD	Headache/Mig	raine Fev	er/Pain _	Asthma _	Allergy
Side Effects/Precautions START DATE	/_	/	STOP DA	ATE	/	/
All controlled all students a all students a self-Administed to keep/take to Student will n	I, stimulant and the stimulant and the street Emergench is medication of share this not share the share the share the share the share end to s	els.  cy Medication: Stu n on his/her own l nedication with an properly labeled p	dication must be deen to be deen that be deen that be deen the months when the months with the deen that the deen	e given and instructed a edical neces	supervised by and is capable ssity. <u>r.</u>	y school personnel for
- Treatment i Tovider (1 Kilv	1)		Date		1 Hone	
TO BE COMPLETED BY PA	RENT OR LEGA	AL GUARDIAN				
I hereby give my permission	on for my child	(named above) to	receive this stat	ted medicati	ion at school.	
I assume full responsibility I hereby release WCS Board as a result of any medication dose/medication changes will pick-up unused/ disc	, their agents a n administratio . <b>I agree to fur</b>	nd employees from n. <b>I will provide a</b> n <b>nish medication ir</b>	any and all liabil new medicatior n an original, pr	ity that may form each operly labe	occur school year a led pharmacy	
*Parent/Legal Guardian Statement Phone Numbers						
_						
Bus Driver Notified	] YES	□ NO □	N/A			
Bus Driver Notified □  Student demonstrates a			,	dication.		
	dequate knowl	edge to keep, carry	and take this me			

Date

School Nurse