School Medication Administration Authorization Form

This order is valid only for the 2026-2027 school year.

This form must be completed fully in order for WCA to administer the required medication. A new medication administration form must be completed at the beginning of each school year, for each medication, and each time there is a change in dosage or time of administration of a medication.

- Prescription medication must be in a container labeled by a pharmacist or prescriber.
- Non-prescription medication must be in the original container with the label intact.
- An adult must bring the medication to the school.

Prescriber's Authorization

Name of Student: _____ Date of Birth: _____ Grade: _____

Condition for which medication is being administered: _____

Medication Name: _____ Dose: _____ Route: _____

Time/frequency of administration: _____If PRN, frequency: _____

If PRN, for what symptoms: _____

Relevant side effects: ☐ None Expected ☐ Specify: _____

Medication shall be administered from: _____ to: _____
Month/Day/Year Month/Day/Year

Prescriber's Name/Title: _____
(Type or Print)
Phone: _____ Fax: _____
Address: _____
Prescriber's Signature:_____
(Original signature or signature stamp only)
Date: _____

(Use for Prescriber's Address Stamp)

Parent/Guardian Authorization

I/We request designated school personnel to administer the medication as prescribed by the above prescriber. I/We certify that I/We have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I/We understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. I/We authorize the school nurse to communicate with the health care provider as allowed by HIPPA.

Parent/Guardian Signature:_____ _____ Date: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Self-Carry/Self Administration of Medication Authorization/Approval

Self-carry/self administration of medication (including emergency medication) may be authorized by the prescriber and must be approved by the school according to the medication policy.

Prescriber's authorization for self-carry/self administration of medication: _____Date: _____
Signature

School approval for self-carry/self administration of medication: _____Date: _____
Signature