Anthony Wayne Local Schools
Prescribed Medication Administration Form

STUDENT INFORMATION		School Year:
Student Name:		Date of Birth:
Address:		
School:	Grade:	Homeroom Teacher:
List known drug allergies / reactions:		

Prescriber Authorization

Name of medication:		Reason:
Date to begin medication:		Date to end medication:
Dosage	Route	Time/Interval
Treatment in the event of an adverse reaction:		
Special instructions:		
Prescriber Signature:		Prescriber Name:
Date:		Phone:

I understand that according to Anthony Wayne Board of Education Policy 5330 (Use of Medication), this form must be completed by the parent/guardian prior to administration of medication by designated school personnel.
☑I authorize a designated employee of the Anthony Wayne Board of Education to administer the above medication.
☑I release and agree to hold the Board of Education, its officials and its employees harmless from any and all liability foreseeable for damages or injury resulting directly or indirectly from this authorization.
☑I understand that medication must be in the original container.
☑I understand that all medications must be administered according to directions on the medication label.
☑I also understand that a responsible adult must deliver/pick up the medication to/from school.

Parent/Guardian Signature	Date
Contact #1 Name & Phone Number	Contact #2 Name & Phone Number

Please contact your child's school with any questions or concerns.