Wesleyan Christian Academy
Medication Administration Form

To be completed and signed each year by physician/designee and parent for <u>non-prescription</u> and <u>prescription</u> medications.

No medications (non-prescription or prescription) will be administered by either school personnel or self (student) without the written authorization of a physician/designee and parent. Dosage and route for non-prescription medication will be administered according to manufacturer's recommendations on the label unless otherwise indicated by physician. Generic substitutions may be used for non-prescription medications listed. Submit a new form during the school year if there are changes or additions. This form is also the authorized form used for off-campus activities, including overnight trips.

TO BE COMPLETED AND SIGNED BY PHYSICIAN/DESIGNEE AND PARENT/GUARDIAN:

Student name_____Grade _____ School Year _____

Drug Allergies (if none, state none) _____

<u>NON-PRESCRIPTION MEDICATIONS IN CLINIC</u>:

☐ Tylenol	☐ Tylenol Liquid	☐ Ibuprofen	☐ Ibuprofen Liquid
☐ Cough Drops	☐ Benadryl 25 mg	☐ Benadryl Liquid 12.5 mg/5 ml	☐ Polysporin Ointment
☐ Vaseline	☐ Benadryl Lotion	☐ Tums	☐ Mylanta

☐ **All of the Medications Above**

<u>PRESCRIPTION MEDICATIONS</u>

Please list any prescription medications to be administered during the school day, including overnight field trips.

_____ _____ _____ _____
Name of medication Dosage Route Time

Reason for medication _____

Possible side effects: _____ Order in effect until (date):_____

_____ _____ _____ _____
Name of medication Dosage Route Time

Reason for medication _____

Possible side effects: _____ Order in effect until (date):_____

_____ _____ _____ _____
Name of medication Dosage Route Time

Reason for medication _____

Possible side effects: _____ Order in effect until (date):_____

For Epinephrine injectors, Inhalers for asthma, Glucagon and Insulin <u>ONLY</u>.
All other medications must be administered by the school nurse or designee.
This student is both capable and responsible for self-administering this medication: NO ____ YES- Unsupervised ____
This student may carry this medication: NO ____ YES ____

Physician/Nurse Practitioner/Physician Asst./Dentist Signature: _____Date: _____

Physician Address/Phone Number: _____

I request my child be administered the prescription/non-prescription medications as indicated in the physician's order above.

Parent/Guardian Signature: _____ Date: _____

TO BE COMPLETED BY THE SCHOOL: Date Received_____ School Nurse _____