Worthington Schools
Medication Authorization Form
For Prescription Medications

**** A new form must be completed for each medication change and each school year.**

I hereby request and give my permission to the school nurse or his/her designee to assist in administering prescription medications to my child. (Note that according to Worthington School Board Policy, all prescription medications to be administered to pupils in grades PK-12 must be delivered to, stored in and dispensed from the building health office by the school nurse or nurse's designee.)

Name of Student_____Date of Birth_____School_____Grade___Teacher_____
Address of Student_____

_____ _____ _____
Medication Dosage Route

Medication is to be taken at the following time(s):_____

I/We understand and acknowledge that school district personnel are under no obligation to render the assistance requested and that such assistance may, in the absence of the school nurse, be rendered by an employee of the district who is not medically trained. I/We hereby release the Worthington City School District, its Board of Education, its officials and employees including the school nurse and the nurse's designee from any and all liability for damages or injury directly or indirectly resulting from the performance or failure of performance of the assistance requested.

Furthermore, I/We understand that parental responsibility to be: (1) to deliver the medication to the school; (2) to notify the school if the child changes physicians; (3) to obtain a revised statement, signed by the physician who originally prescribed the drug, and to deliver it to the school, when the child's therapy is changed in any manner; and (4) to recover any medication not administered by the school

_____ _____ _____ _____
Date Signature of Student's Parent(s) or Legal Guardian(s) Home Phone Cell/Work Phone

****ALL MEDICATION MUST BE IN ORIGINAL/PHARMACY LABELED CONTAINERS****

WORTHINGTON SCHOOLS
PHYSICIAN STATEMENT TO AUTHORIZE DISPENSING MEDICATION AT SCHOOL

To the Physician:
The Worthington Board of Education urges you to schedule the taking of medications by students at times outside of school hours. When that is not possible, the receiving and consumption of medications will be permitted, insofar as feasible, during school hours. Medication in pill form is preferred to liquids for use in school.
I verify that this medication must be taken by:

Name of Student:_____

_____ _____ _____
Medication Dosage Route
Medication is to be taken at the following times:_____
Instructions or precautions:_____
Action to be taken if side effects observed:_____
Beginning date prescription_____Expiration date prescription_____Date form completed_____

Physician's Printed Name_____Physician's Signature_____
Office Phone_____Physician's Address_____

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