



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
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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
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****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
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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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