



**AUTHORIZATION FOR MEDICATION DURING SCHOOL HOURS**  
**School Year 2021 - 2022**

**Student Information**

Student Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Please check what program your student is in: WIMA \_\_\_\_ WIHI \_\_\_\_ Grade \_\_\_\_\_

**Medication Information**

Diagnosis or Reason for Medication \_\_\_\_\_

Medication and Dosage \_\_\_\_\_

Form:  Tablet  Capsule  Liquid  MD Inhaler  Nebulizer  Ointment  Other \_\_\_\_\_

Amount to be Given \_\_\_\_\_ Route:  Oral  Injection  Rectal  Inhaled  Other \_\_\_\_\_

Time of Administration \_\_\_\_\_ Important Side Effects:  None anticipated  Yes  
(describe) \_\_\_\_\_

Special storage requirements:  None  Refrigerate  Other \_\_\_\_\_

Start:  Date form received \_\_\_\_\_  Other date \_\_\_\_\_

Stop:  End of school year  Other date \_\_\_\_\_ (Note: permission must be renewed each school year)

**Important Notice to Parent and Physician:**

1. Self-carried means the student will possess and self-administer the medication without supervision. Controlled substances are not allowed to be self-carried. Physician and parent authorization is required and no records are kept by the school.
2. Medication stored by the school for the student, even if self-administered, must have both physician and parent authorization. Records will be kept by the school of each dose taken.

**Physician Authorization**

- School personnel will administer this medication  
----- OR -----
- This student is capable of and may self-administer this medication under the supervision of school personnel.  
----- OR -----
- This student is capable of and may carry and self administer this medication (No controlled substances).

Physician's Name \_\_\_\_\_  
(please print)

Physician's Signature \_\_\_\_\_

Date \_\_\_\_\_

Phone # \_\_\_\_\_ FAX# \_\_\_\_\_

**Parent/Guardian Authorization**

- School personnel will administer this medication.  
----- OR -----
- This student is capable of and may self-administer this medication under the supervision of school personnel.  
----- OR -----
- This student is capable of and may carry and self-administer this medication (No controlled substances).  
Therefore, **I understand and agree to accept:**  
\*any risk that the medication may be lost or stolen,  
\*that the student may misuse the medication,  
\*that the school will not keep any record of the dates or times of medication administration,  
\*that this privilege will be revoked if problems arise from inappropriate use.

Parent/Guardian's Signature \_\_\_\_\_

Date \_\_\_\_\_

Home Phone # \_\_\_\_\_ Work # \_\_\_\_\_



WASHTENAW INTERNATIONAL  
HIGH SCHOOL & MIDDLE ACADEMY

*An International Baccalaureate School*

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**School Acceptance** (needed only for self-administered/self carried medication)

Student has demonstrated safe self-administration of medication.  Yes  No

School Office Signature \_\_\_\_\_ Date \_\_\_\_\_ Building Principal's Initials \_\_\_\_\_