WA-NEE Community Schools

A TRADITION OF EXCELLENCE

Medication Form

The Wa-Nee Community School Corporation requires students who will be administered medication during school hours to provide the school with a permission form signed by both the physician and the parent/guardian.

Name of Student: _____ **Grade:** _____

Date of Birth: _____ **School:** _____

TO BE COMPLETED BY PHYSICIAN

Name of Medication: _____

Dosage: _____

Time or Frequency: _____

Rationale for giving _____

Possible side effects/Special Instructions: _____

Beginning Date:	**Ending Date:**

Date: _____ **Physician's Signature:** _____

TO BE COMPLETED BY PARENT/GUARDIAN

I give permission for my child _____ *to receive the above medication as directed by our physician. I also give the school and physician permission to communicate and release information to each other as needed.*

Date: _____ **Parent/Guardian's Signature:** _____

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