

Websterville Christian Academy

Distinctively Different by God's Design

PRESCRIPTION MEDICATION FORM

Name of child: _____ DOB: _____ Grade: _____ Date: _____

All medication to be administered at school must comply with the following school policies:

1. The school nurse or designated staff member **must have this completed form** before medication will be given at school. Your physician may fax this form to WCA at (802) 622-0033.
2. The school nurse or designated staff member must approve and **administer the first dose** of any medication given at school.
3. The school nurse or designated staff member may delegate administration of subsequent doses to another school staff member.
4. A **parent/adult** must bring the medication to school in an appropriately labeled pharmacy container.
5. All medicine **must be kept in the office under lock & key** unless the health care provider, parent and administrator have given permission for the student to keep the medication for self-administration.

Medication Order:

Medication: _____ Strength: _____

Dosage/Route/Time: _____

Start Date: _____ End Date: _____

Reason for Giving: _____

Physician: _____ Phone number: _____

Parent's Permission: I give permission for _____ to share information with WCA concerning
Healthcare Provider
my child's Healthcare Provider medication(s).

I give permission for the medication prescribed to be given to my child at school by the school nurse or designated staff member.

Signature of Parent/Guardian: _____ Date: ___/___/___

Vermont Department of Health ~ Vermont Standards of Practice: School Health Services