



# Student Medication Administration Authorization 2026-2027 School Year

Student Name \_\_\_\_\_ Grade \_\_\_\_\_ Teacher \_\_\_\_\_

Weight (For over-the-counter dosing information) \_\_\_\_\_

*This form must be completed fully and turned into the Nurses' Office BEFORE any medication will be administered. A new Student Medication Administration Authorization (SMAA) must be completed and signed by the parent/guardian and physician.*

- 1) At the beginning of each school year.
- 2) Any time there is a change in the prescription.
- 3) Prior to overnight field trips requiring this medication.

**\*THIS FORM IS NOT TO BE USED FOR FOOD ALLERGY EMERGENCY MEDICATIONS. Epinephrine and antihistamines should be prescribed by the physician on a Food Allergy Action Plan form**

MUST BE COMPLETED AND SIGNED BY PHYSICIAN

**PHYSICIAN'S SIGNED AUTHORIZATION CONFIRMS THE NECESSITY OF THIS MEDICATION TO BE ADMINISTERED DURING THE SCHOOL DAY OR DURING AN OVERNIGHT FIELD TRIP.**

Name of Medication\* \_\_\_\_\_

Dosage \_\_\_\_\_ Frequency \_\_\_\_\_ Route \_\_\_\_\_

Physician's note to the School Nurse regarding this medication/diagnosis \_\_\_\_\_

Physician's Name \_\_\_\_\_

Phone Number \_\_\_\_\_ Fax \_\_\_\_\_

Address \_\_\_\_\_

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

**\*The WCGS registered nurses reserve the right to decline administering prescribed medications that are not approved by the FDA**

MUST BE COMPLETED AND SIGNED BY PHYSICIAN

**PHYSICIAN'S SIGNED AUTHORIZATION CONFIRMS THE NECESSITY OF THE SELECTED OVER THE COUNTER MEDICATIONS TO BE ADMINISTERED DURING THE SCHOOL DAY OR DURING AN OVERNIGHT FIELD TRIP. All listed over the counter medications will be supplied by the school. Anything not listed is required to be sent in by parents in original bottle. Only listed medication with a check mark will be given. Dosing will be based on weight, or age if weight not provided.**

\_\_\_\_ Acetaminophen \_\_\_\_ Ibuprofen \_\_\_\_ Diphenhydramine \_\_\_\_ Cetirizine Hydrochloride

\_\_\_\_ Calcium Carbonate \_\_\_\_ First Aid Anti-Itch Cream \_\_\_\_ Cough Drops Other: \_\_\_\_\_

Physician's Name \_\_\_\_\_

Phone Number \_\_\_\_\_ Fax \_\_\_\_\_

Address \_\_\_\_\_

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

**\*The WCGS registered nurses reserve the right to decline administering over the counter medications that are not approved by the FDA**

**ASTHMA INHALER SELF CARRY AUTHORIZATION:** WCGS will permit students to self-carry and self-administer an asthma inhaler in a prescription labeled box during the school day, field trip or school sponsored event ONLY with parent/guardian initials agreeing to ALL the following:

\_\_\_\_\_ (initial) I give permission for this student to **self-carry** and **self-administer** his/her asthma inhaler.

\_\_\_\_\_ (initial) I have provided WCGS with a **copy of the prescription label** on the asthma inhaler box.

\_\_\_\_\_ (initial) I agree to take full responsibility for the risks and consequences to my student if I do not provide the Nurse's Office or field trip chaperone with an **additional** prescribed asthma inhaler.

**Administration of medication by Wheaton Christian Grammar School personnel is contingent upon the following guidelines:**

1. The PHYSICIAN'S ORDER must be fully completed, signed by the parent/guardian and physician, and turned into the Nurses' Office BEFORE this medication is administered to the student.
2. The medication must be brought to the school office in a pharmaceutical container labeled with the student's name, name of medication, the dosage, and all pertinent instructions. Students permitted to self-carry/self-administer asthma inhalers must carry prescription labeled inhaler.
3. The school will maintain a written record of any medication dispensed, including the student's name, name of medication, date/time it was administered, and by whom.
4. This form is valid for one school year only. Forms must be renewed each school year, with parent and physician signatures.
5. Any change in prescription of this medication requires a new Student Medication Administration Authorization (SMAA), complete with parent/guardian and physician signatures.
6. Overnight field trip medications require physician authorization, diagnosis, dosage and instructions to be provided to the Nurse's office 48 hours prior to departure. Students may self-carry/self-administer an asthma inhaler if parent authorization and prescription label is on file in Nurse's office.
7. Asthma inhalers and any other prescription medications maintained in the Nurse's office **WILL NOT** be sent on school-sponsored events outside of school hours (including, but not limited to, athletic competitions, scholastic tournaments and extracurricular activities and trips) unless it is an overnight field trip. A parent/guardian is strongly recommended to attend such after-hour events and provide emergency medications as necessary. A parent/guardian is strongly recommended to transport their student to and from such after-hour events. Any parent who does not attend, or who allows their student to use transportation arranged by the school, knowingly and willingly assumes all medical and health risks to their student.

**PARENT/GUARDIAN AUTHORIZATION**

I hereby confirm that I have reviewed and understand Wheaton Christian Grammar School's policy regarding the administration of prescription and over the counter medications. On my behalf, I authorize Wheaton Christian Grammar School and its employees to administer or attempt to administer to my child this lawfully prescribed medication in the manner described on the Physician's Order. I certify that I have legal authority to consent to medical treatment for the student named within this document, including the administration of medication at school. In addition, I agree to release, and hold harmless and indemnify, the School, its employees, agents and volunteers, from and against any and all liabilities, claims, damages, causes of action and possible causes of action whatsoever arising out of or related to any loss, damage or injury (including death) incurred or resulting from the administration or attempt to administer said medication. I agree and specifically authorize school administration to provide health information about this student to school employee's or approved parent chaperone's if, in the school's discretion, there is a need for them to know this information, to provide a safer environment for the student.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_