MEDICATION AUTHORIZATION FORM
NON-PRESCRIPTION MEDICATIONS

☐ I DO NOT WANT ANY MEDICATION GIVEN TO MY CHILD AT SCHOOL.

Parent/Guardian Signature: _____ Date: _____

I, the parent/guardian of _____, hereby authorize WGS and its employees and agents, in my behalf, to administer to my child lawfully non-prescribed medication. I further acknowledge and agree that when the lawfully non-prescribed medication is so administered, I waive any claims I might have against the WGS and its employees and agents arising out of the administration of said medication.

_____ _____
Date Parent or Guardian Signature

CONSENT FOR ADMINISTRATION OF SCHOOL OFFICE MEDICATIONS

Student Name _____ Grade_____
Medication Allergies _____
List medications this student takes regularly _____
_____
Health conditions _____

Please check any medications you wish to be made available to this student:
For headaches/fever/muscle aches/menstrual cramps/pain:
☐ Acetaminophen 325 mg (Tylenol) 1-2 tablets every 4 hours as needed
☐ Ibuprofen 200 mg (Advil/Motrin) 1-2 tablets every 4-6 hours as needed

For mild stomach discomfort:
☐ Antacid (Tums) 1-2 tablets as needed

For mild skin irritation: Topical Medications
☐ Hydrocortisone Cream 1%
☐ Antibiotic Ointment (Neosporin)
☐ Antiseptic Spray

I give permission for my child, _____, to receive any medication indicated above as deemed necessary by the school office. I understand that generic equivalent medication may be used. Whenever possible, arrangement should be made so that medications can be given at home.

Parent/Guardian Signature_____ Date: _____