Willows Preparatory School
Authorization for Medication Administration at School
2025-2026

Please note: **ALL** medication administered at school (including over-the-counter) **require authorization from a Licensed Healthcare Provider** with prescriptive authority (MD, DO, ND, DMD, DC, PA, ARNP, or CNM). For emergency medications such as epinephrine or albuterol, which require an Emergency Care Plan, this requirement can be met by the medication order section of their ECP. Please review our Medication Policies before submitting any medications.

PARENT/GUARDIAN REQUEST

Student's Name: _____ Date of Birth: _____ Grade: _____

I understand and acknowledge that:

- All medications I provide must be unexpired and properly labeled in their original box.
- My signature gives permission for exchange of information between the School Nurse, pertinent school staff, and the Healthcare Provider regarding this medication order.
- Students may not carry medication unless certain criteria have been met under the Medication Policy.

Please check only ONE box and then sign below:

❑ I request and authorize Willows Preparatory School to **assist my child** in taking the medication in accordance with the LHP's instructions below or attached.

❑ I request that my child be allowed to **self-carry and self-administer** the medication in accordance with the LHP's instructions below or attached. My student and I understand the responsibility of self-carrying medication at school and recognize the school will not track compliance, expiration, or amount. I agree to hold harmless and indemnify the school and its officers, employees, and agents against all claims, judgments, or liabilities arising out of the self-administration and carrying of medication by my student. *I also understand that this requires permission from the school nurse and administrator, who have the final determination.*

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Name: _____ Phone number: _____

LICENSED HEALTHCARE PROVIDER (LHP) REQUEST

Medication Name: _____ Dosage: _____ Method/Route of administration: _____

TIME(S) for scheduled medications or INDICATIONS/SYMPTOMS for as-needed medications (be specific):

_____

Is student capable of safely self-carrying medication? ☐ Yes ☐ No

Is student capable of safely self-administering medication? ☐ Yes ☐ No

Possible side effects of medication and special instructions, if any: _____

I have determined that the medication named below is advisable during the school day, for the period of:
☐ Duration of current school year (includes summer school) ☐ Other dates: _____ to _____

LHP Name: _____ Office Phone: _____

Willows Preparatory School

Parental Consent for Medication Administration at School

2025-2026

I hereby authorize Willows Preparatory School staff to administer medication to the below-named student in accordance with the attached prescription or licensed healthcare provider's instructions, for the authorized period of _____(Month/Yr) to_____(Month/Yr) or end of the school year (including summer school: Yes___ No__).

Student's Name: _____ Date of Birth: _____ Grade: _____

Name of Medication	Dosage	Expiration Date	Reason/Diagnosis

I understand that Willows Preparatory School will administer medication (either prescribed or over-the-counter) to my student *only* if said medication is accompanied by a separate signed LHP's request indicating 1) the name of the student, 2) name of the medication, 3) strength and dosage, 4) quantity, and 5) frequency of administration. ***The written consent of a health care provider with prescriptive authority is required for prescription medications and all over-the-counter medications.***

I understand that it is my responsibility to administer medication to my child, and that I will not hold WPS responsible for failing to administer medication, or for administering it improperly.

I understand that all medications I provide must be in their original box with all necessary supplies (dosage cup, etc.) and be unexpired. WPS staff cannot administer expired medication to my student and it is my responsibility to provide non-expired medication to the school when needed.

I understand that students may not carry medication on their persons or store medication at WPS in lockers, cubbies, backpacks, etc. All medications (either prescribed *or* over-the-counter) must be kept at the front office or with the school nurse, with certain exceptions for students who self-carry emergency medication as outlined in our WPS Medication Policy.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Name: _____ Phone number: _____