**Student name:**_____

**Washington Jesuit Academy**
**MEDICATION AUTHORIZATION FORM**
**(To be filled out by the physician dispensing the medication)**

Student's Name_____ Age _____

Medication _____ _____

Diagnosis_____

Dose _____ Time (s) of Administration_____

Duration of medication _____ Route of administration_____

Possible side effects and significant information_____

_____

Physician's Name (please print) _____

Telephone Number (include area code) _____

_____ _____
Physician Signature Date

**PARENTAL PERMISSION**

I/We hereby give permission for _____ to take _____at school as ordered by his/her physician identified above. I/We understand that it is my/our child's responsibility to report to the administrative offices at the appropriate time for the administration of the medication. I/We further understand that it is my/ our responsibility to furnish the medication and any authorized refills. I/We further understand that the School, its officers, agents and /or any employee who administers any drug to my/our child, in accordance with written instructions from the prescribing physician shall not be liable for damages as a result of an adverse drug reaction or any other injury suffered by my/our child due to the administration or failure to provide the drug, other than for damages resulting from the gross negligence, recklessness, or intentional infliction of harm by WJA, its officers, trustees, agents, or employees.
The School reserves the right to not administer medication should circumstances warrant such actions.

I/We understand that the medication must be brought to school in the original appropriately labeled container by me/us. If I /we cannot bring it to school, I /we will call the school to let them know my/our child will be bringing it and how much medication is in the container.

Name of Parent /Guardian (please print)_____

_____ _____
Signature of Parent /Guardian Date