



west sound
academy
IB WORLD SCHOOL

Medication Authorization Form 2023-2024

Student Name: _____ Grade: _____

Name of Medication: _____ Dosage: _____

Time of Day: _____ Start Date: _____ End Date: _____

Possible Side Effects: _____

Physician's Name: _____

Phone: _____ Address: _____

Parent/Guardian Permission:

I grant permission for the above named student to receive the listed medication according to the specifications listed above. I understand that it is my responsibility to refill medication as necessary, and to ensure that WSA receives the medication in its original container with original labeling.

Parent/Guardian Signature: _____

Date: _____

***ALL PRESCRIPTION MEDICATION MUST BE BROUGHT TO THE OFFICE
IN ITS ORIGINAL CONTAINER ALONG WITH THIS SIGNED AUTHORIZATION FORM***