west sound academy
IB WORLD SCHOOL

Medication Authorization Form 2024-2025

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