Healthcare Provider Medication Authorization

west sound academy
IB WORLD SCHOOL

School Year: 2026–2027

This form is completed by the student's licensed healthcare provider when provider authorization is required under West Sound Academy's Medication Administration Policy.

Student Information

Student Name:

Date of Birth:

Medication Order

Medication Name:

Diagnosis or Medical Condition (optional):

Authorization

Dosage:

Route of Administration:

☐ Oral
☐ Inhaled
☐ Injection
☐ Topical
☐ Eye
☐ Ear
☐ Nasal
☐ Other _____

Administration Schedule

Administer:

☐ At approximately _____
☐ As needed (PRN)

If PRN, indicate the symptoms or conditions for administration:

Maximum dose within a school day (if applicable):

Duration of Authorization

Effective Date: _____
Expiration Date: _____
☐ Through the end of the current school year

Special Instructions

Please indicate any precautions, activity restrictions, potential side effects requiring monitoring, emergency procedures, or other instructions for school personnel.

Emergency Response

If this medication is not administered as ordered or fails to relieve symptoms, school personnel should:

☐ Contact parent/guardian.

☐ Activate Emergency Medical Services (911).

☐ Follow the student's emergency care plan.

☐ Other: _____

Self-Carry / Self-Administration (Complete only if applicable)

I certify that this student has demonstrated the knowledge and skills necessary to safely self-carry and/or self-administer this medication.

☐ Student may self-carry

☐ Student may self-administer

Healthcare Provider Authorization

I certify that the medication and instructions above are medically appropriate for administration during the school day and during school-sponsored activities, when applicable.

Healthcare Provider Name:

Credentials:

Clinic/Practice:

Phone:

Signature:

Date: