WILLOWS ACADEMY

Medication Authorization Form

Student Name: _____

Grade: _____ Date of Birth:_____

To be completed by a licensed physician for all medications

The licensed physician signature is not required for asthma inhalers

Medication Start Date: _____ Discontinuation Date: _____

Medication: _____

Route of administration: _____

Dosage: _____ Frequency/Time: _____

Diagnosis/Reason: _____

Purpose of medication: _____

Possible Side Effects: _____

Physician Authorization for self-carry or self-administration of epinephrine, insulin, or asthma inhaler

Do you authorize this student to self-carry epinephrine, insulin, or asthma inhaler?	No _____ Yes _____ N/A _____
Do you authorize this student to self-administer epinephrine, insulin, or asthma inhaler?	No _____ Yes _____ N/A _____

Authorizing Physician Name (print)::_____

Authorizing Physician Signature: _____

Date:_____ Physician Phone:_____

Physician Address: _____

WILLOWS ACADEMY

Medication Authorization Form

Student Name: _____

Grade: _____ Date of Birth:_____

To be completed by parent or guardian

I hereby acknowledge that I am the parent and/or legal guardian of the above referenced student and that I am primarily responsible for administering medication to my child. I hereby authorize Willows Academy and its employees and agents to administer to my daughter or to allow my daughter to ____ self-carry an/or ____self-administer (please initial next to the applicable authorizations) asthma medication, epinephrine auto-injectors or insulin, while under the supervision of the employees and agents of Willows Academy, her lawfully prescribed medication according to the above instructions

I further acknowledge and agree that Willows Academy and its employees and agents are to incur no liability, except for willful and wanton conduct by any of the said parties, as a result of any injury arising from administering the prescribed medication noted above to my daughter. I further acknowledge and agree that, in absence of willful and wanton conduct on the part of Willows Academy and its employees and agents, I waive any claims that I might have against said parties arising out of administering the prescribed medication noted above to my child. In addition, I agree to indemnify and hold harmless Willows Academy and its employees and agents, either jointly or severally, except claims based on willful and wanton conduct on behalf of said parties, from and against any and all claims, damages, causes of action or injuries incurred or resulting from administering my child's prescribed medication as noted above.

Parent or Guardian Signature: _____

Date:_____

This form does not completely describe Allergy, Diabetes, or Asthma Care; please have your physician complete the appropriate care plan available at willowsacademy.org/health-forms. Authorizations expire annually and new forms are required at the start of each school year. All medications must be brought to school by a parent or guardian in an appropriately labeled pharmacy container; non-prescription medication must be brought in the original packaging.

v.7-2023