



Midwestern PKWY Campus: 1615 Midwestern Pkwy,  
 Wichita Falls, TX 763022  
 Preschool Campus: 4729 Neta Ln.  
 Wichita Falls, TX 76302  
 (940) 763-1347  
 www.wichitachristian.com

## Prescription Medication Authorization

**Student Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**To be completed by the student's parent/guardian:**

I, as the parent/guardian of the above-named student, understand that:

\_\_\_\_  
initial Medication must be in the original container with a pharmacy label stating the student's name, medication, dose and instructions.

\_\_\_\_  
initial A physician signature is required for all prescription medications given at school, and any changes in a medication or dosage will require a new physician signature/order.

\_\_\_\_  
initial A separate form requiring a physician signature is required for students to self-carry or self-administer a medication for diagnoses such as diabetes, asthma and/or anaphylaxis.

\_\_\_\_  
initial Unused, discontinued or expired medication must be picked up by the parent/guardian at the end of the school year or within 7 days after the discontinued use or expiration date. Medications not picked up will be disposed of.

\_\_\_\_  
initial This form must be completed each school year for WCS staff to administer prescription medication to a student.

I, as the parent/legal guardian of the above-named student, do hereby request and grant permission for designated Wichita Christian School personnel to administer the medication(s) listed below as indicated on the prescription label and consult with the student's physician/licensed prescriber regarding any questions that may arise with regard to the listed medication(s) or medical condition(s) being treated by the medication(s).

On behalf of the above-named student, I also agree and do hereby waive and release all claims for loss, damage, or injury against Wichita Christian School and any personnel or other person arising directly or indirectly out of any act or omission relating to the receipt, administration, or execution of this request.

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

Relevant Diagnosis	Medication Name & Strength (ex. 5mg)	Dose	Route	Start - End Dates	Time/Frequency	Possible Side Effects

Notes: \_\_\_\_\_

**Physician Name:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_