



Recipient of the "Distinction In Performance" Award
Every Year Since 2006

Dr. Curtis Cain
Superintendent of Schools

Cheri Thurman
Assistant Superintendent
Special Services

Laura Smith
Director of Ancillary Services

Stacy Schwartz
Special Services Coordinator

**AUTHORIZATION FOR PRESCRIPTION/OVER-THE-COUNTER MEDICATIONS TO BE TAKEN
DURING SCHOOL HOURS**

School: _____ Fax Number: _____

The following section is to be completed by the PARENT/GUARDIAN

Child's Name: (Last) _____ (First) _____

Child's DOB: _____

I request that medicine(s) prescribed by the authorized physician below be administered to my child according to physician's directions. I give permission to the school nurse to destroy any medication remaining at the end of the school year, if I do not pick it up by the last day of school.

Parent Name: _____

Parent Signature: _____

Date: _____

THE FOLLOWING SECTION IS TO BE COMPLETED BY THE PHYSICIAN

Diagnosis/Reason For Medication: _____

Name of Medication: _____ OTC: _____

Route/Form of Medication: PO Inhaler Injection Rectal

If PRN, Specify: When Indicated (Signs/Symptoms) _____ (Tylenol/Ibuprofen/Cold Remedies etc.)

Time: _____ Frequency: _____

Start Date: _____ Stop Date: _____

Dosage: _____ For episodic/emergency events only: _____

Side Effects: (Describe) _____

Date: _____ Physician Signature: _____

Physician Name: (Please Print) _____

Address: _____ Phone Number: _____

Wentzville R-IV School District – Special Services

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