Baldwin-Whitehall School District

Administration Office: 4900 Curry Road • Pittsburgh, Pennsylvania 15236-1817
Telephone: 412-884-6300 • FAX: 412-885-7802 • Website: www.bwschools.net

Baldwin High School	J. E. Harrison Education Center	R. A. Lutz Elementary School	Whitehall Elementary School	McAnnulty Elementary School
412-885-7500, Ext. 4	412-885-7530, Ext. 4	412-885-7535, Ext. 4	412-885-7525, Ext. 3	412-714-2020, Ext. 3
Fax: 412-885-6652	Fax: 412-885-6766	Fax: 412-885-6641	Fax: 412-885-7559	Fax: 412-714-2024

AUTHORIZATION FOR ADMINISTRATION OF PRESCRIPTION MEDICATION AT SCHOOL

(Permission for use of inhalers and over-the-counter medication is on separate forms.)

PART I – TO BE COMPLETED BY PARENT/GUARDIAN

Student Name: ______________________ **Birth Date:** ____________

School: ____________________ **School Year:** ____________ **Grade:** ________

I request that Baldwin-Whitehall School District administer the prescribed medication below to the student identified above. I agree to relieve the Baldwin-Whitehall School District, its officers, directors and employees of any responsibility for the benefits or consequences of the prescribed medication and acknowledge that the Baldwin-Whitehall School District bears no responsibility for ensuring the medication is taken.

I assure that the first dose has been given at home and that my child did not have any adverse reactions to it.

______________________ Print or Type Name of Parent/Guardian

______________________ Parent/Guardian's Signature

______________________ Relationship to Student

______________________ Phone Number

____________ Date

PART II – TO BE COMPLETED BY PHYSICIAN/LICENSED PRESCRIBER

I agree to relieve the Baldwin-Whitehall School District, its officers, directors and employees of any responsibility for the benefits or consequences of the prescribed medication and acknowledge that the Baldwin-Whitehall School District bears no responsibility for ensuring that the medication is taken.

Diagnosis	Medication	Strength	Dose	Time	Route	Possible Side Effects

Symptoms of conditions for which medication is ordered: ______________________

Other medication(s) the child is taking: ______________________

Other considerations/directions: ______________________

Start Date: ____________ Stop Date: ____________
(All authorizations expire at the end of the school year.)

______________________ Print or Type Name of Physician/Licensed Prescriber

______________________ Physician's/Licensed Prescriber's Signature

______________________ Address

______________________ Phone Number

____________ Date