



# 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](http://www.bwschools.net)

Baldwin High School  
412-885-7500, Ext. 4  
Fax: 412-885-6652

J. E. Harrison Middle School  
412-885-7530, Ext. 4  
Fax: 412-885-6766

R. A. Lutz Elementary School  
412-885-7535, Ext. 4  
Fax: 412-885-6641

Whitehall Elementary School  
412-885-7525, Ext. 3  
Fax: 412-885-7559

McAnnulty Elementary School  
412-714-2020, Ext. 3  
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