Baldwin-Whitehall School District

Administration Office: 4900 Curry Road • Pittsburgh, Pennsylvania 15236-1817
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Website: www.bwschools.net

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

(Permission for use of inhalers is on separate form.)

Student Name: _____ Birth Date: _____

School: _____ School Year: _____ Grade: _____

Medical Condition	Medication	Strength	Dose	Time	Route	Possible Side Effects
1.						
2.						
3.						
4.						

Over the counter medication as designated by physician: _____

Other considerations/directions: _____

Start Date: _____ Stop Date: _____

(All authorizations expire at the end of the school year.)

Physician/Licensed Prescriber Authorization

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.

Print or Type Name of Physician/Licensed Prescriber _____ Physician's/Licensed Prescriber's Signature

Address _____ Phone Number _____ Date

Parent/Guardian Authorization

1. I request that the above medication(s) be given during school hours as ordered by this student's physician/licensed prescriber. I also request the medication(s) be given on field trips, as prescribed.
2. I release school personnel from liability in the event adverse reactions result from taking the medication(s).
3. I will notify the school of any changes in the medication(s) (ex: dosage change, medication discontinued, etc.).
4. I give permission for the school nurse to communicate with the student's teachers about the student's health condition(s) and the action of the medication(s).
5. I give my permission for the school nurse to consult with the above named student's physician/licensed prescriber regarding any questions that arise with regard to the listed medication(s) or medical condition(s) being treated by the medication(s).
6. I give permission for the medication(s) to be given by designated personnel as delegated by the school nurse.

NOTE: Medication is to be supplied in the original/prescription bottle.

I request that school personnel administer as directed by my child's physician. I acknowledge that a school nurse may not be present for this purpose on many occasions and a person without any medical training will administer the medication. I acknowledge my awareness that the administration of medication under the anticipated circumstances might pose a substantial risk of injury to, including death of my child. On behalf of myself and my child, I hereby exonerate, release and discharge Baldwin-Whitehall School District, its officers, directors, and employees, from any and all claims, causes of action and liability whatsoever in respect of any injury to, including death of my child which may result at any time in the future by reason of any action taken in good faith and absent gross negligence, pursuant to this request. I further agree to indemnify, defend and hold harmless Baldwin-Whitehall School District, its officers, directors and employees from any suit or proceeding brought to enforce any such claim, cause of action or liability. I enter into this agreement or release and indemnity voluntarily and without coercion for the purpose of inducing the employees of Baldwin-Whitehall School District to administer medication to my child.

Date _____ Parent/Guardian Signature _____ Relationship to Student