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	Harrison Middle School	McAnnulty Elementary	Paynter Elementary	Whitehall Elementary
412-885-7500, Ext. 4	412-885-7530 Ext. 4	412-714-2020, Ext. 3	412-885-7535, Ext. 3	412-885-7525, Ext. 3
Fax: 412-885-6652	Fax: 412-885-6766	Fax: 412-714-2024	Fax: 412-885-6641	Fax: 412-885-7559

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