WHITEHALL DISTRICT SCHOOLS

AUTHORIZATION FOR PRESCRIBED MEDICATION OR TREATMENT

The following form is necessary for any student to use prescribed medications or to receive a specified medical treatment in school. Form must be completely filled out.

Student Name: _____ Birthdate: _____

Address: _____

School building: _____ Grade: _____

I am requesting permission for my child named above to (check one):

☐ Receive prescribed medication / treatment by authorized school personnel

☐ Self-administer prescribed medication / treatment in my presence or that of authorized school personnel in accordance with the doctor's prescription.

Medication Name: _____

Dosage amount: _____

Frequency to give: _____

Physician Name: _____ Physician #_____

An adult will assume the responsibility for safe delivery of the medication to school. The parent will notify the school immediately if there is any change in the treatment / medication. The parent releases and agrees to hold the Board of Education, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization. Medication must be picked up by parent before the end of the school year or school personnel will dispose of.

_____

Parent / Guardian Name **(PLEASE PRINT)**

_____ _____

Parent / Guardian Signature Date

Contact Numbers: Home: _____

Cell: _____ Work: _____

PHYSICIAN STATEMENT

To the Physician:

The school district requires that the following information be provided to ensure safe delivery of medication or treatments to the student named by parent to receive such therapy.

Student Name_____

I have prescribed the following medication_____

_____

Beginning Date: _____ Ending Date: _____

Dosage, frequency, special instructions, or precautions:_____

_____

_____

I have prescribed the following treatment for the following condition_____

_____

_____

_____

Physician Signature_____ Telephone:_____

Printed / Typed Name _____ Date: _____

AUTHORIZATION FOR STAFF

The following staff members are authorized to administer the abover-prescribed medication(s) / treatment(s):

_____

_____

_____

_____
Principal