WILMINGTON AREA SCHOOL DISTRICT

400 WOOD STREET

NEW WILMINGTON, PA 16142

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

Student's Name_____DOB_____

Building_____ Grade/Homeroom_____

Name of Medication (A separate form must be completed for EACH medication that is to be administered)

_____

Dosage_____

Desired time of administration_____

Reason medication prescribed _____

Special circumstances or Side effects_____

Listing of other medications prescribed for student _____

Period of time for which medication is prescribed_____

Prescribing Physician's Name _____

Prescribing physician's signature OR copy of signed prescription attached

_____ OR

Signed Prescription attached:_____

I hereby agree to hold harmless and indemnify the Wilmington Area School District and its employees against any and all claims, damages, expenses, attorney's fees, suits, cause or causes of action in law or equity for the administration of the medication authorized above.

_____ _____ _____

Printed Name of Parent/Guardian Signature of Parent/Guardian Date

Amount of Medication received _____

By_____ _____

Signature of Certified School Nurse Date

NOTE: ALL MEDICATION MUST BE BROUGHT TO SCHOOL IN THE ORIGINAL PRESCRIPTION/MANUFACTURER'S BOTTLE OR IT WILL NOT BE ADMINISTERED AT SCHOOL.