

WHITEHALL-COPLAY SCHOOL DISTRICT

Prescription Medication Dispensing Form

To the Physician:

Please complete this form if you request your patient to receive a prescription medication during school hours.

Medication must be brought in the original prescription bottle. The medication will be kept in the health room. It will be the student's responsibility to go to the health room at the correct time and request the medication. In the absence of the school nurse, the principal or designee may give the medication.

Student's name: _____ Grade: _____ Teacher: _____

Medication prescribed: _____

Prescribed dosage* and frequency: _____

Time of day: _____

Reason for medication: _____

Side effects: _____

Is child taking any other medication: _____

Name of other medication(s): _____

The authorization shall be in effect from: _____ to _____

Date: _____ Physician's signature: _____

Print name of physician: _____

Address of physician: _____

Phone number of physician: _____

I do hereby release, discharge, and hold harmless, the Whitehall-Coplay School District, its agents and employees, from any and all liability and claim of whatsoever nature for the administration of the above medication to my child and for any and all injuries resulting there from.

Student may carry inhaler with him/her and use as prescribed by physician.

Signature of parent: _____ Date: _____

Telephone number: _____

****If the dosage is changed at any time, physician must complete new form. Please request additional forms as needed from the school nurse.***