

**WHITNALL SCHOOL DISTRICT**  
**PARENT AND PHYSICIAN AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION**

School: \_\_\_\_\_ School Year: \_\_\_\_\_ Grade: \_\_\_\_\_  
Name of Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ Home phone: \_\_\_\_\_  
Parent(s) Name: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Name of Medication: \_\_\_\_\_  
Dosage: \_\_\_\_\_ Route: \_\_\_\_\_ Hour(s) Administered: \_\_\_\_\_  
Reason for Medication: \_\_\_\_\_

Physician Prescribing Medication: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_

If approved by their physician, I allow my child to carry their Epi-Pen and/or Inhaler,

I agree to notify the school in writing at the termination of this request or when any changes in the above order are necessary.

\_\_\_\_\_  
(Signature of Parent/Legal Guardian) \_\_\_\_\_ (Date)

Note: Before medication prescribed by a physician can be administered by school personnel, a signed statement from the physician which includes the conditions and circumstances for administering the medication, the prescribed dosage, and the frequency of administration must be on file. The 'Physician Order for Medication' below may be used for this purpose.

**Physician Order for Medication**

Name of Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Name of Medication and Dosage: \_\_\_\_\_

Medication Frequency/Time: \_\_\_\_\_

Conditions under Which Medication Should Be Given: \_\_\_\_\_

Contraindications / Side Effects: \_\_\_\_\_

If the medication is an inhaler or Epi pen:

Check box if student may carry the inhaler with him/her.

Check box if student may carry Epi-Pen with him/her

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Address: \_\_\_\_\_ Phone: \_\_\_\_\_