WINDBER AREA SCHOOL DISTRICT
MEDICATION PERMISSION/ORDER FORM
(For Prescription AND Over The Counter Medications)

Student:_____ Date of Birth_____

Teacher/Homeroom_____ Grade _____ Date_____

In accordance with school policy, medication(s) should be given at home before and/or after school. However, when this is not possible, prior to receiving medication at school, each student must provide the school nurse with a *Medication Permission /Order Form* from a licensed prescriber and signed by the parent/guardian. All medication must be in an original prescription bottle or packaging.

TO BE COMPLETED BY THE PHYSICIAN OR LICENSED PRESCRIBER

Name of Medication_____

Reason for Medication_____

Form of Medication/Treatment: (check one)
[ ]Tablet/capsule [ ]Liquid [ ]Inhaler [ ]Injection [ ]Nebulizer [ ]Other_____

Schedule and Dose to be given at school:_____

Restrictions and/or side effects:_____

Special Storage Requirements:_____

Is student able to self administer this medication? (check one)
[ ]No [ ]Yes-Supervised [ ]Yes-Unsupervised

This student may carry this medication: [ ]No [ ]Yes

***This med may be put on hold for field trips out of the district [ ]No [ ]Yes

Physician's Signature:_____ Date_____

Address_____Telephone:_____

TO BE COMPLETED BY THE PARENT/GUARDIAN

I give my permission for (name of student)_____
to receive the above medication at school according to school policy.

Parent's Signature_____Date:_____

THE WINDBER AREA SCHOOL DISTRICT WILL INCUR NO LIABILITY FOR THE USE OF UNAUTHORIZED DRUGS OR THE MISUSE OF DRUGS