



# Wellpinit School District #49

P.O.Box 390, 6270 Ford Wellpinit Rd.  
Wellpinit, WA 99040 (509) 258-4535



## PHYSICIAN'S AUTHORIZATION FOR MEDICATION AT SCHOOL

Student's Name \_\_\_\_\_

Birthdate \_\_\_\_\_

Medication is ordered to be given to a student at school only when necessary. The principal will designate person(s) responsible to dispense the medication. The nurse will delegate school employee(s) to administer oral medications.

### THIS PORTION TO BE COMPLETED BY THE PHYSICIAN

Diagnosis or reason for medication: \_\_\_\_\_

MEDICATION	DOSAGE/MODE	TIME TO BE GIVEN	SIDE EFFECTS

Duration without a subsequent order \_\_\_\_\_

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

Physician's Name \_\_\_\_\_

Physician's Address \_\_\_\_\_

Physician's Phone Number \_\_\_\_\_

Physician's Fax Number \_\_\_\_\_

### PARENT/GUARDIAN PERMISSION

The medication is to be furnished by me in the original container, labeled by the pharmacy with the name of the medication, amount to be taken, and the time of day to be taken. The physician's name is on the label. I understand that my signature indicated my understanding that reasonable care will be exercised in administration of the medication. The school accepts no responsibility for adverse reactions when the medication is dispensed in accordance with the physician's directions. If medication remains after the course of treatment, I will collect the medication from the school or understand that it will be destroyed.

Signature of parent or guardian \_\_\_\_\_ Date \_\_\_\_\_

This authorization is good for the current school year only  
WSD: