Side A

Williamsport Area School District
Division of Student Services
Department of School Health Services

PHYSICIAN'S ORDER FOR PRESCRIPTION MEDICATION

Name of Student: _____

DOB: _____

Allergies: _____

Medication	Strength	Dosage	Time to be Given	Route of Administration	Duration of Order

****Medication may be given 60 minutes before or after time indicated.**

Purpose of medication: _____

_____

_____

Side effects which may be exhibited in school: _____

***Medications and field trips:**

This medication may be omitted during an off-campus field trip: yes OR no (circle one)

A written physician's order is required to change or discontinue a medication.

_____ _____

Physician's Name – **PRINTED** Physician's Signature

_____ _____

Phone Date

(OVER ☞)

2/2024

Side B

PARENTAL AUTHORIZATION AND INDEMNIFICATION FOR THE DISPENSATION OF PRESCRIPTION MEDICINE

I, _____, parent or legal guardian of
(name of parent)

_____, hereby authorize the Williamsport Area School
(name of student)
District and its nurses and/or employees designated by building principals and properly instructed by its nurses to give prescription medicine to _____.
(name of student)

Prescription medicine will be accompanied by the prescribing physician's instructions.

I agree that the district and its employees are not to be held liable for giving medicine in accordance with this Authorization. I agree to hold harmless and indemnify the Williamsport Area School District and all of its employees against any and all claims, damages, expenses, attorney's fees, suits, cause or causes of action that may be brought against the district or its employees in connection with giving such medicine.

This Authorization shall be effective unless revoked by me in writing. I intend to be legally bound by this Authorization. This authorization and the accompanying prescription must be renewed for each school year.

_____
Signature of Parent and/or Guardian

_____
Date

<u>Permission</u>

I, _____, give permission for the school nurse or Health
(name of parent)
Room Technician to contact Dr. _____ to discuss the medication that has been prescribed for my child. This permission will be considered valid for one year from the date signed. This permission may be revoked by written request at any time.

_____
Signature of Parent and/or Guardian

_____
Date

2/2024