Authorization for Medications & Treatments at School

Student Name: _____ DOB: _____
Please Print

ATTENTION PARENTS:

If your student needs to take medications at school, **this form needs to be signed by your doctor** and on file at Washington School for the Deaf.

We appreciate the name of your students physician if they receive medication from you during the year.

PHYSICIAN/PRIMARY CARE PROVIDER INFORMATION:

Physician's Name: _____ Clinic Name: _____
Please Print

Address: _____

Phone Number: _____ Fax Number: _____

MEDICATION	DOSAGE	ROUTE	TIMES PER DAY	REASON FOR MEDICATION

Diet Restriction(s): _____

Activity Restriction(s): _____

Can student self-carry medications? ☐ **Yes** ☐ **No**

Can student self-administer medications (including inhalers)? ☐ **Yes** ☐ **No**

Provider (physician, nurse practitioner, or physician assistant) signature required for WSD Nurses to administer prescription and over-the-counter medication(s), for WSD food service to offer special diet plan, and/or WSD staff to ensure activity restrictions.

Physician Signature: _____ Date: _____

WSD Physician Signature: _____ Date: _____