BETHLEHEM AREA SCHOOL DISTRICT
Bethlehem, Pennsylvania

AUTHORIZATION FOR MEDICATION DURING SCHOOL HOURS

Date: _____

My child, _____, must receive the following prescribed medication during school hours in order to maintain sufficient health to participate in the school program. I will provide the medicine in an appropriately labeled, original pharmacy container.

Name of medication: _____

Prescribed dosage: _____

Time schedule: _____

Diagnosis and necessity of medication during schools hours: _____

_____

Physician: _____

Physician telephone number: _____

List side effects of medication: _____

_____

Expected duration of medication regime: _____

If the student may carry and be responsible for Epipen or metered dose inhaler, please initial here.

_____ prescriber _____date
_____ parent _____date

Field Trips - Medication will not be sent on field trips unless specific arrangements have been made. School Nurses do not accompany students.

School Delays or Early Dismissals – In case of a delay or early dismissal, medications scheduled to be given during those times will not be given.

I do hereby release, discharge and hold harmless, Bethlehem Area School District, its agents and employees, from any and all liability and claims whatsoever in connection with the administration of the above medication to my child.

_____

Signature of Parent or Guardian Signature of Physician

Rev. 9/05