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: ____

Physician: ____

Physician telephone number: ____

Pharmacy: ____

Pharmacy phone number: ____

List side effects of medication: ____

____

Diagnosis and necessity of medication during schools hours: ____________________

____

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

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.

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

______________________________ Signature of Parent or Guardian

______________________________ Signature of Physician