Bethlehem Area School District
Bethlehem, PA
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 school 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**