HOLY INFANCY SCHOOL

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 school hours: _____

_____

Physician: _____

Physician telephone number: _____

List side effects of medication: _____

_____

Expected duration of medication regime: _____

Pharmacy: _____ Pharmacy phone number: _____

In the event a student is not in the building at the prescribed medication time i.e. a student trip or late entry the student may receive the medication upon entry to school or the medication may be held per parental request. _____ Initials

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. 05/18