Mt. Lebanon School District
Health Services

AUTHORIZATION FOR MEDICATION

#440 (2/2014)

Dear Parent/Guardian:

For safety reasons, the administration of student medications, either prescription or non – prescription, during school hours is strongly discouraged.

If a physician deems it necessary for your child to take medications, either prescription or non-prescription during the school day, **the Authorization for Medication Form (on reverse side) must be completed by both a parent/guardian and physician and returned to your child's health office prior to any medication being administered**

The following summarizes the procedure;

- Prescription medication must be in the current and appropriate pharmacy labeled container.
- Over the counter medication must be in the original container and the type of non-prescription medication must match the physician's orders.
- A new, completed form by both the physician and parent is required for each medication change, dose change and for each new school year.
- It is the responsibility of your child to report to the health office for his/her medication.

Please remember that your child may not receive his/her medication if these procedures are not followed.

Please feel free to contact your child's school nurse if you have any questions or concerns regarding this matter.

Thank you for your cooperation.

Health Services Department

(OVER)

MT. LEBANON SCHOOL DISTRICT HEALTH SERVICES

Authorization for Medication, prescription and non-prescription, to be given during school hours.

Student's Name_____ Student's ID #_____ School_____

Date of Birth_____ Sex_____ Grade/Homeroom_____
Physician's Name_____ Telephone_____

TO BE COMPLETED BY LICENSED PRESCRIBER:

MEDICATION		
DOSAGE/ROUTE		
TIME OF ADMINISTRATION		
LENGTH OF ADMINISTRATION (i.e. the school year or a shorter time)		
REASON FOR MEDICATION		
ADMINISTRATION INSTRUCTIONS		
SIDE EFFECTS		
SELF-ADMINISTRATION ***This student is authorized to self-carry his/her Inhaler or Auto Injecting Epinephrine and medicate her/himself***		**YES_____/Physician initials_____** **NO_____/Physician initials_____**
SIGNATURE OF LICENSED PRESCRIBER		
DATE		

TO BE COMPLETED BY PARENT/GUARDIAN:

In consideration of Mt. Lebanon School District granting our request to dispense certain medication to our child and/or allow self-administration of medication, the undersigned parents/guardians, on our own behalf and on behalf of our minor child, hereby release, indemnify and hold harmless Mt. Lebanon School District and its School Board, Administrators, Teachers, Secretaries, Nurses and Employees from and against any and all claims, damages, action, or causes of actions resulting and/or arising out of or connected directly or indirectly with the request for or the dispensing of the medication listed above to our said child. **I understand and agree that medical information may be shared with appropriate personnel. I authorize my child's physician to release any medical information that may be required by district personnel. I understand and agree that emergency medication may be administered by district employees who are not nurses.**

Parent/Guardian Signature: _____

Date:_____ Home # :_____ Cell #:_____ Work#:_____