210-AG-0
Administrative Guideline
Adopted: August 16, 2021
Reviewed:

Authorization for Prescription Medication during School Hours

_____ must receive the following PRESCRIBED MEDICATION
Full Name of Student
during school hours in order to maintain sufficient health for participation in the school program.

Name of Medication _____

Prescribed Dosage _____

Time Schedule _____

Length of Time (days/weeks) _____

Reason for Administration* _____

Possible Side Effects _____

_____ _____ _____
Health Care Practitioner Signature *Date* *Phone Number*

I do hereby release, discharge, and hold harmless, the Unionville-Chadds Ford School District, its agents and employees, from any and all liability and claim whatsoever for the administration of the above medication to my child/ward should there develop an allergic or other reaction from the medication.

_____ _____
Parent/Guardian Signature *Date*

***Emergency medications (i.e. inhalers and Epi-pens) may be carried by middle school and high school students with parent's and health care practitioner's permissions.**

_____ has permission to carry and self-administer this prescription medication.
Full Name of Student

_____ _____
Parent/Guardian Signature *Date*

_____ has demonstrated the ability and is qualified to safely self-administer this prescription medication.
Full Name of Student

_____ _____
Health Care Practitioner Signature *Date*