Mt. Lebanon School District

Heath Services
7 Horsman Drive
Pittsburgh, Pennsylvania 15228-1107

(4/19;10/19;5/20)

Authorization for Medication

For safety reasons, the administration of student medicines, 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 nonprescription during the school day, the **AUTHORIZATION FOR MEDICATION FORM** (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:

- ***Physician orders MUST be dated July 1st or after for the upcoming school year***
- *Prescription medication must be in the current and appropriate labeled pharmacy container.*
- *Over the counter medication must be in the original, unopened container and the type of over the counter medication must match the physician's orders.*
- *A new form completed by **both** the physician and parent is required for **each medication,** 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.*
- *Emergency medications (Epinephrine Auto injector and/or Rescue inhaler and/or Diabetic Supplies) may be carried by students after completion of:*

Authorization for Medication Form
Self Carry Form

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 certified nurse if you have any questions or concerns regarding this matter.

Thank you for your cooperation.
Health Service Department

OVER

Mt. LEBANON SCHOOL DISTRICT HEALTH SERVICES

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

3/18; 4/19; 10/21

Student's Name:_____ ID# _____School_____

Date of Birth_____Sex_____ Grade/Homeroom_____

Physician's Name_____ Office Phone Number_____

TO BE COMPLETED BY LICENSED PRESCRIBER:

MEDICATION	
DOSAGE	
TIME OF ADMINISTRATION	
LENGTH OF ADMINISTRATION (i.e. the school year or a shorter time)	
REASON FOR MEDICATION	
ADMINISTRATION INSTRUCTIONS	
SIDE EFFECTS	
SELF-ADMINISTRATION/SELF CARRY (This student is authorized to self-carry his/her Rescue Inhaler or Auto Injecting Epinephrine and/or Diabetic Supplies and medicate himself/herself.	**YES___ PHYSICIAN'S INITIALS_____** **NO___ PHYSICIAN'S 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, actions or causes of action resulting and/or arising out of or connected directly or indirectly with the request for or the dispensing of medication listed above to our said child. **I understand and agree the 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 Phone #_____Work #_____Cell #_____