CHARLEROI AREA SCHOOL DISTRICT

Charleroi Area Elementary Center
75 Fecsen Drive
Charleroi, PA 15022
Phone: 724-483-5554
Fax 724-489-9367

Charleroi Middle/High School
100 Fecsen Drive
Charleroi, PA 15022
Phone: 724-483-3600/724-483-3573
Fax: 724-489-9128/724-483-2294

AUTHORIZATION TO ADMINISTER PRESCRIBED MEDICATION

Student Name: _____ D.O.B. _____ Homeroom: _____
Student must receive the following prescribed medication during school hours in order to maintain sufficient health to participate in school.

Name of Medication: _____

Is this a PRN medication? Yes_____ No_____ If yes, reason: _____

Dosage: _____ Time(s): _____ Frequency: _____

Expected Duration of Medication administration (example: all year, two weeks, etc): _____

Possible side effects: _____
_____
_____

Other medications taken outside of school hours: _____
_____

Allergies: _____

Special Instructions: _____

For middle/high school students- student may carry inhaler (check yes or no)
Yes_____ No_____
If the student is using inhaler more frequently than prescribed or is continuing to have difficulty, they MUST see the school nurse IMMEDIATELY.

Physician's Name (printed): _____ Physician's phone number: _____

Physician's Signature: _____ Date: _____

I/We do release, discharge, and hold harmless the Charleroi Area School District, its agents and employees from any and all claims or liabilities whatsoever arising out of the administration of the above medication to my child. I/We do authorize the Charleroi Area School District to disclose protected health information contained on this authorization in order to comply with the physician's orders set forth above, or for the purpose of treatment, payment, or health care operations (45 C.F.R. § 164.502(a)(I)(iii) and §164.506).

Intending to be legally bound, I/We have executed this release on:

Date: _____ Signature of Parent/Guardian: _____

Parent/Guardian Name (printed): _____ Parent/Guardian Phone Number: _____