TRINITY AREA SCHOOL DISTRICT
231 PARK AVENUE
WASHINGTON, PA 15301
(PRESCRIPTION MEDICATION)
PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF
MEDICATION DURING SCHOOL HOURS

________________________________ ____ enrolled in Grade ____ at Trinity ________________________________
(Name of Student) (Age) (Elementary, Middle, High School)

must receive the medication listed below during school hours. The particulars related thereto are as follows:

Name of Medication/Prescribed Dosage ________________________________

Time(s)/Length of Time of Administration
(Number) (Days/Weeks) ________________________________

Reason for Administration/Need to Administer During School Day (Unless specifically stated herein and supported by reasons for said conclusion, it will be presumed that the administration of the medication set forth above is not necessary for the child to participate in school programs and failure to so administer said medication will not substantially limit or prohibit participation in or access to an aspect of the student's school program.) ________________________________

Other Medications Being Taken or
Prescribed/Possible Side Effects/Allergies ________________________________

Additional Recommendations or Comments ________________________________

Dated: ____________________ ________________________________
(Signature of Physician)

TO PHYSICIAN: IT IS ESSENTIAL THAT THE REASON FOR ADMINISTRATION, THE NEED TO ADMINISTER DURING THE SCHOOL DAY, AND THE IMPACT THAT FAILURE TO PROVIDE SAID MEDICATION WOULD HAVE ON THE STUDENT BE COMPLETELY STATED IN THIS AUTHORIZATION**. IF INHALER, MUST IT BE CARRIED BY STUDENT?**

PARENTAL PERMISSION FOR ADMINISTRATION OF
MEDICATION AND RELEASE AND WAIVER OF LIABILITY

We/I do hereby authorize the Trinity Area School District, its agents and employees to administer the medication set forth in the Physician's Authorization above in the manner described above to:

________________________________ ________________________________
(Full Name of Student) (Address of Student)

and further do hereby release, discharge and hold harmless the Trinity Area School District, its agents and employees, from any and all liability and claim whatsoever for the administration or failure to administer the above medication to the aforesaid student including any allergic or other reaction from the medication set forth above. **If an inhaler**, **We/I do/do not authorize student to retain inhaler.**

We/I acknowledge that we are required to comply in all respects with Policy No. 210 of the Trinity Area School District known as Administration of Medication During School Hours, a summary of which is attached hereto and incorporated by reference herein and that in the event the student is authorized to self-administer medication, that said privilege may be withdrawn and action taken against said student for violation of this and other policies of the school district.

Dated: __________ __________ ____________________ ____________
(Witness) (Signature of Parent/Guardian) (Phone No. Work/Home)

Dated: __________ __________ ____________________ ____________
(Witness) (Signature of Parent/Guardian) (Phone No. Work/Home)

__________ ____________________ ____________
(Witness)
(Signature of Parent/Guardian)
(Phone No. Work/Home)