CANON-McMILLAN SCHOOL DISTRICT
One North Jefferson Avenue
Canonsburg, PA 15317

AUTHORIZATION FOR MEDICATION DURING SCHOOL HOURS

(Prescription and Over the Counter)

DATE: _____ GRADE: _____

_____ must receive the following medication
(Full Name of Pupil)
during school hours in order to maintain sufficient health to participate in the school program. All medication must be in the original manufacturer's container or the pharmacy labeled bottle.

Name of Medication: _____

Prescribed Dosage: _____

Time Schedule: _____

Length of Time (days/weeks): _____

Reason for Administration: _____

Possible Side Effects: _____

Regarding asthma inhalers, the child (check only one) _____ is _____ is not able to self-administer the medication. If the student can self-administer, s/he has permission to carry the inhaler.

Regarding epi-pens, the child (check only one) _____ is _____is not permitted to carry the epi-pen with them.

I do hereby release, discharge, and hold harmless the Canon-McMillan School District, its agents and employees, from any and all liability and claims whatsoever arising from the administration of the above medication to my child/ward which I hereby expressly authorize.

_____ _____

(Signature of Physician) ***(Signature of Parent/Guardian)***