

**Elizabethtown Area School District**  
**Medication Authorization and Information Form**

Dear Parent or Guardian:

The administration of medication during the school day is sometimes unavoidable. The medication policy of the Elizabethtown Area School District states that before any medication, prescribed or over-the-counter, may be administered to or by any student during school hours, a **signed written order from the prescribing medical provider and the written request of the parent/guardian**, giving permission for such administration, is required. Only medication accompanied by the information requested on the Medication Authorization Form will be administered during school hours.

To provide a safe environment for all students, **every medication must be brought to school by a parent or guardian** and taken to the Nurse’s Office immediately upon entering the building. The Nurse’s Office can only accept a 30-day supply of any one medication. All medication, whether prescribed or over-the-counter, must be received in the original container in which it was dispensed. Any change to the prescribed order requires the completion of a new form.

Thank you for your cooperation,  
The Elizabethtown Area School District

**Request For Medication During School Hours**

To be completed by Physician, Nurse Practitioner, or Physician’s Assistant:

\_\_\_\_\_  
Name of Student                                  D.O.B.                  Teacher/Grade                                  Date

\_\_\_\_\_  
\* Name of Medication                                  Dosage/ Unit                                  Route

\_\_\_\_\_  
Time Medication is to be Administered                                  or *Remainder of School Year*  
Number of Days to be Administered

\_\_\_\_\_  
Reason/Purpose                                  Possible Side Effects

**\*Inhaler Use:** This student was taught and has demonstrated competence with self-administering his/her inhaler and responsible behavior in the use of the medication. He/she has permission to carry and self-administer his/her inhaler, as prescribed, when needed. *The student shall notify the nurse or designee immediately following each use.* If the student abuses or ignores the school policies, the privilege to carry the medication will be reviewed by school administration.

Provider Initials                                  \_\_\_\_\_  
Yes                                  No

\_\_\_\_\_  
**Physician/NP/PA Signature**                                  **Printed Name**

\_\_\_\_\_  
Phone#                                  Date  
\*Signing verifies that the above plan has been prescribed by you, the child’s physician, and should be carried out by the school he/she attends.

\_\_\_\_\_  
**Signature of Parent/Guardian**                                  **Printed Name**

\_\_\_\_\_  
Phone#                                  Date  
\*\*Signing verifies that you, the parent/guardian, give permission for the school staff to carry out the administration of the above prescribed plan in your absence and relieve the Board and its employees of responsibility for the benefits or consequences for such medication and its administration.