Avella Area School District
1000 Avella Road
Avella, PA 15312

Authorization for Prescription and Nonprescription

Medication During School Hours

Name:_____

Date:_____ Age:_____ Grade:_____

_____(full name of student) must receive the following medication during School hours in order to maintain sufficient health to participate in the school program.

Name of Medication: _____

Prescribed Dosage: _____

Time Schedule: _____

Length of Time (Days/Weeks): _____

Reason for Medication: _____

Other Medications Being Taken or Prescribed: _____

_____

Possible Side Effects: _____

Instructions for Use: _____

_____

If Inhaler or Epi Pen, is the student to carry? YES NO

*If the student is to carry one, it is strongly recommended that an extra be given to the school nurse.

Any Curtailment of Activity? _____

_____

List Any Other Medications Child is Taking: _____

_____

I do hereby release, discharge and hold harmless – the Avella Area School District, it's agents and employees, from any and all liability and claim whatsoever for the administration of the above medication to my child/ward should there develop and allergic or other reaction from the medication.

_____ _____

PARENT/GUARDIAN SIGNATURE PHYSICIAN'S SIGNATURE

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