HARMONY TOWNSHIP SCHOOL
PARENTAL AND PHYSICIAN AUTHORIZATION FOR MEDICATION ADMINISTRATION TO STUDENTS

A. TO BE COMPLETED BY PARENT/GUARDIAN:

I request that my child ________________________________ in grade ______ receive the medication prescribed below by our physician. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the medication will be kept in the health office and administered by the school nurse. I hereby release, discharge and hold harmless Harmony Township School, its agents and employees from any and all liability and claim whatsoever for any injury arising as a result of the self-administration of the medication listed below.

Signature of Parent/Guardian: ____ Date: _______

Address: ____ Phone: ____________________

B. TO BE COMPLETED BY PHYSICIAN

I request that my patient, as listed below, receive the following medication:

Student name: ____ DOB: ________________

Diagnosis: ____

Name of medication: ____

Prescribed dosage and route of administration: ___________________________________

Time of administration: ____

Expected duration of treatment: ____

Possible side effects or adverse reactions: _______________________________________

FOR ASTHMA INHALERS OR EPIPENS PLEASE INDICATE WHETHER OR NOT PUPIL HAS BEEN INSTRUCTED IN THE CORRECT USE OF AND MAY OR MAY NOT CARRY AND SELF-ADMINISTER, AS NEEDED FOR EMERGENCY USE:

YES: ________ NO: ________

Physician Name (PLEASE PRINT): ___________________________________ Phone: ___________

Physician Signature: ____ Date: __________________