Allentown SCHOOL DISTRICT
31 South Penn Street § P.O. Box 328 § Allentown, PA 18105
Administration Center § 484-765-4235 § Fax: 484-765-4239

Student Services Department
Health Services
Last Updated 10/4/2021

AUTHORIZATION TO CARRY/SELF-ADMINISTER PRESCRIBED MEDICATION

FOR PHYSICIAN USE ONLY

PHYSICIAN AUTHORIZATION

Student:_____D.O.B._____Grade:_____

Diagnosis:_____

Medication and dose:_____

Time of circumstances requiring self-administration:_____

Possible side effects/conditions to observe:_____

_____

IN MY OPINION, THIS STUDENT SHOWS THE CAPABILITY TO CARRY AND SELF-ADMINISTER THE ABOVE NAMED MEDICATION. THIS AUTHORIZATION IS VALID FOR ONE SCHOOL YEAR FROM DATE SIGNED.

Physician signature:_____Date:_____

Printed physician's name:_____Phone:_____

_____

FOR STUDENT USE

I have been instructed in the proper use of my prescribed medication and fully understand how and when to use it. I will use this medication only according to the above instructions from my doctor. I will not share this medication under any circumstances. I understand that, should another student use my medication, the privilege of carrying my medication with me may be taken away. I will immediately report lost or missing medication to the nurse. I also agree to come directly to the school nurse, a teacher, a coach, an athletic trainer or a principal after using my medication in order to report its use.

Student signature_____Date:_____

_____

PARENT/GUARDIAN USE

I request that my child (named above) be permitted to carry/self-administer the above medication as per the above medication as per the order of the physician. I understand that the medication must be in a properly labeled pharmacy container. I understand that I, the parent/guardian, accept the legal responsibility should the above medication be lost, given to, or taken by a person other than the above-named student. I hereby waive any and all claims arising out of the above-named student's self-administered medication and release all individual employees of the school district from liability arising out of my son/daughter's self-administration of medication in school. I understand that neither the school district, nor its employees, have legal responsibility to ensure that the medication is taken or when the above-named student administers his or her own medication and bears no responsibility for the benefits or consequences of the administration of the medication.

Parent/Guardian signature:_____Date:_____

_____

FOR SCHOOL USE

We accept the above physician's order, student's statement, and parent/guardian request. We will permit the above-named student to carry/self-administer the prescribed medication. We reserve the right to take appropriate action, which may include withdrawing this privilege, if the student shows signs of irresponsible behavior or if there is a safety risk.It is preferable that additional prescription labeled medication be kept in the school nurse office in case the first is left home or lost.

School Nurse Signature:_____Date:_____