Shady Side Academy
Authorization for Medications to be Taken During School Hours

Please complete this form if your child must take medication(s) during the school day. This form should be signed by your child's physician and returned to the nurse's office at your child's school.

Student _____Grade_____

Physician's Name _____Physician's Phone_____

Prescription medication must be in a current pharmaceutical container with a prescription label attached and brought to the school nurse with this completed form. Over-the-counter medications must be in their original container, labeled with the child's name and dosage required.

Check one of the following: (Please read carefully and see medication policy for more information.)

This option *must* be checked for *all* medications except inhalers, epipens, fast-acting glucose and insulin:

___ I give the school nurse permission to administer this medication to my child as described below.

This option may *only* be used for inhalers, epipens, fast-acting glucose and insulin:

___ I give my child permission to keep this medication with him/her throughout the school day and self-medicate as described below. I understand that the school nurse has the right to deny and/or revoke this privilege if the student fails to demonstrate that he/she is responsible enough to carry and/or self-administer this medication per the guidelines listed in Shady Side Academy's medication policy.

I hereby indemnify Shady Side Academy or any of its personnel, employees, or agents from any claim, demand, cause of action, or liability asserted against them arising out of the students taking, or failing to take, the medication in the dosage or at the time prescribed below. I understand that the permission granted will be terminated in accordance with the physician's directive, or automatically at the close of the school year.

_____ _____

Date **Signature of Parent/Guardian**

Name of Medication _____
Dosage_____
Reason for the Medication _____
If medication is to be given daily, at what time _____
If medication is to be given PRN, describe indications _____
List significant side effects _____
Length of time medication is to be given _____
Other Information _____

_____ _____

Date **Signature of Physician**