Carlynton School District (Elementary)
AUTHORIZATION FOR MEDICATION DURING SCHOOL HOURS
(Prescription and Over-the-Counter)

DATE: _____ Child's GRADE_____

Child's NAME: _____ **must receive the following medication during school hours in order to maintain sufficient health to participate in the school program. All medication must be in the original manufacturer's container or the pharmacy labeled bottle and be brought to school by responsible adult. Your doctor may fax the order to your child's school for your convenience. Carnegie 412-429-3253 or Crafton 412-922-7587**

Name of Medication: _____

Prescribed Dosage: _____

Time Schedule for Administration: _____

Discontinuation date: _____

Reason for Administration: _____

Possible Side Effects: _____

Allergies: _____

Additional directions: _____

I do hereby release, discharge and hold harmless the Carlynton School District, its agents and employees, from any and all liability and claims whatsoever arising from the administration of the above medication to my child/ward which I hereby expressly authorize.

_____ _____
Licensed Prescriber Name Printed Parent/Guardian Name Printed

_____ _____
Licensed Prescriber Signature Parent/Guardian Signature

_____ _____
Phone Number Phone Number

In accordance with school district policy, medication(s) should be given at home before and/or after school. However, when this is not possible, prior to receiving the medication at school, each student MUST provide the school nurse with a School Medication Authorization form signed by the student's licensed prescriber and the student's parent/guardian.