MOUNTAIN VIEW SCHOOL DISTRICT

Phone 570-434-2501 Fax 570-434-9582

AUTHORIZATION FOR MEDICATION AT SCHOOL

Date_____ Grade_____

My child (please print first & last name), _____, may/must receive the following prescribed or over the counter medication during school hours, and school sponsored activities in order to maintain sufficient health to participate in the educational process. I will provide the medicine in an appropriately labeled, original, pharmacy container.

Physician/Provider, please complete form below:

Name of medication _____

Dosage/Route _____

Time schedule _____

Diagnosis _____

Side effects of medication_____

The student is capable of self-carrying and administering the following medications, if ordered (please circle):

INHALER	YES	NO
EPINEPHRINE	YES	NO

Physician name (please print) _____

Physician phone number:_____

Pharmacy_____ Pharmacy phone number_____

I do hereby release, discharge & hold harmless, the Mountain View School District, its agents & employees, from any and all liability and claims whatsoever in connection with the administration of the above medication to my child.

_____ _____

Signature of Parent/Guardian Signature of Physician

MUST BE SIGNED BY PARENT AND DOCTOR