POTTSGROVE SCHOOL DISTRICT

AUTHORIZATION FOR MEDICATION ADMINISTRATION

Child's Full Name:_____ Grade_____
Date of Birth: _____ Allergies: _____
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PHYSICIAN REQUEST

NAME of Prescribed Medication: _____

REASON: _____ DOSE: _____

ROUTE: _____ TIME TO BE GIVEN AT SCHOOL : _____

SIDE EFFECTS: _____

MEDICATION IS TO BE ADMINISTERED AS FOLLOWS: (check if applicable)

1. _____ until completed. Last dose: _____
2. _____ entire school year. Daily_____ PRN_____
3. _____ other_____
4. _____ **INHALERS ONLY** *(Student is able to carry and self-administer during entire school year)*
   _____ **INHALERS ONLY (***Elementary student (K-5) may self administer ONLY at extracurricular activities)*
5. _____ **Asthma Emergency Action Plan needed.** (Physician to provide)

_____ _____
PHYSICIAN SIGNATURE **PRINTED NAME**

_____ _____
DATE **PHONE NUMBER**
****

PARENT REQUEST

I, the parent of _____ request that the employees (nurse or designee) of the Pottsgrove School District administer the above named medication as prescribed by my child's physician. My signature on this document constitutes a complete waiver of liability claim in any and all respects against the Pottsgrove School District and the Board of Directors and all employees unless the District is negligent with regard to any claim for an injury in connection with the dispensation of the prescribed medication.

Additionally, I agree to provide the medication to the school in the original pharmacy *or manufacturer* labeled container. I also accept responsibility to provide a physician's note and my written instructions if the medication is to be changed or discontinued. I give permission for the school and physician to communicate regarding this medication/medical condition.

_____ _____
DATE **SIGNATURE OF PARENT/GUARDIAN**

Please list all medication currently being taken by child: _____
Revised 06/23