



**BETHLEHEM AREA SCHOOL DISTRICT HEALTH SERVICES
AUTHORIZATION FOR MEDICATION DURING SCHOOL HOURS**

FOR THE PHYSICIAN:

Student Name: _____ must receive medication prescribed by me for the following condition: _____.

This medication must be given during school hours in order to maintain sufficient health and participation in the school program. Medication _____

Prescribed daily dosage _____

Time and dosage to be given in school _____

Duration period _____

Possible side effects _____

Permission is given to carry inhaler, epi-pen during school hours for middle and high school. ☐ Yes ☐ No

Does the child demonstrate knowledge of how to use inhaler, epi-pen for Middle and High School? ☐ Yes ☐ No

Date _____

Physician Signature: _____

Print Name of Physician _____

Phone Number _____

FOR THE PARENT OR GUARDIAN:

I give permission for the Bethlehem Area School District and/or their designee to administer the above medication to my child (*Student Name*) _____ as prescribed by the physician.

I agree to deliver medication to school in a labeled prescription bottle. The label must include the name of the medication, the prescribed dosage, the physician's name and the pharmacy.

I agree to deliver a new supply of medication to the school, as needed.

I authorize the Bethlehem Area School District to exchange health-related information with the above-named Physician.

I understand that a new medication authorization form must be completed by the parent and physician if the dosage is changed at any time.

Delayed School Openings – medication given on a schedule will NOT be given late at school when there is a delayed opening, but should be given at the scheduled time at home.

Field Trips – medication will not be sent on field trip unless specific arrangements have been made with the school nurse.

Emergency Procedures /Epinephrine – when anaphylactic symptoms are demonstrated, BASD emergency procedures, including the use of Epinephrine auto injectors, will be followed. Please contact your school's nurse with any concerns.

I agree to pick up my child's medication(s) the last day of school.

Date

Parent(s) or Guardian(s) Signature

MEDICATION PICK UP.

Date picked up _____

Signature of parent(s) or

Guardian(s) _____



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Permission to carry inhaler during school hours epi-pen during school hours for middle and high school ☐ Yes ☐ No

Permiso para tener/usar inhalador/epi-pen durante el horario escolar para Escuela Intermedia y Superior. ☐ Si ☐ No

Fecha _____ Physician Signature _____

Print Name of Physician _____ Phone Number _____

Para el Padre o Guardián:

Por este medio autorizo al Distrito Escolar del Área de Bethlehem a administrarle el siguiente medicamento a mí

Hijo/a (*Nombre*) _____, como lo recetó el doctor.

Estoy de acuerdo en traer el medicamento en una botella con etiqueta. La botella tendrá el nombre del estudiante, el nombre del medicamento, la dosis prescrita, el nombre del medico, y el nombre de la farmacia.

Estoy de acuerdo que el Padre/Guardián debe estar al tanto de la cantidad de medicamento que se tiene en la escuela, y debe traer el abastecimiento necesario de tal medicamento.

Entiendo que en el momento que se cambiara la dosis prescrita, el padre y el medico han de completar nuevos formularios y el padre debe traer a la escuela el formulario con la nueva información.

Autorizo al Distrito Escolar del Área de Bethlehem

comunicarse e intercambiar información con el doctor citado arriba.

Retraso/Apertura Tarde--Los medicamentos que se dan a cierto horario, NO serán dados más tarde en días de retraso al horario escolar. Deberían de ser administrados a la hora indicada en casa.

Paseos Escolares--Los medicamentos NO serán enviados a paseos escolares a menos que se hagan arreglos específicos con la enfermera de la escuela de su hijo/a.

Procedimientos en caso de Emergencias/Epinefrina--Por favor tenga presente que los procedimientos de emergencia de BASD se seguirán en caso de una emergencia. Las inyecciones de epinefrina serán administradas en el caso de que se demostrara síntomas de un ataque anafiláctico. Favor de comunicarse con la enfermera de la escuela de su hijo/a si tiene algunas preguntas o preocupaciones.

Estoy de acuerdo en recoger el medicamento o la medicina de mi hijo/a el último día de clases

Fecha _____

Firma del Padre/Guardián _____

EL MEDICAMENTO O LA
MEDICINA FUE RECOGIDA.

Fecha _____ Firma del
Padre/Guardián _____