AUTHORIZATION FOR MEDICATION DURING SCHOOL HOURS

should receive the following prescribed medication during school hours.

Medication:

Dose:

Time:

Special Instructions:

Diagnosis:

Date Physician Signature

PARENTAL PERMISSION

Please check:

\_\_\_\_\_\_\_\_\_\_\_\_ Please administer/supervise the dispensing/taking of the medication prescribed for my child.

\_\_\_\_\_\_\_\_\_\_\_\_My child has permission to administer an Asthma Inhaler or Epi-Pen to himself/herself. (Student must pass a self-medication assessment evaluated by the school nurse.)

\_\_\_\_\_\_\_\_\_\_\_\_ I give my permission for exchange of information with other health care professionals regarding my child’s health concerns/medications.

I hereby release, discharge and hold blameless the Milton Area School District, its agents and employees, from any and all liability and claim whatsoever for the reaction from the above prescribed medication.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Parent/Guardian Signature

*(over)*