

CONNELLSVILLE AREA SCHOOL DISTRICT

AUTHORIZATION FOR USE OF MEDICATION DURING SCHOOL HOURS

TO: _____ DATE: _____
Full Name of Building Principal

Please permit _____ to take the following medication, according to the instructions of the physician of record as indicated below, during school hours in order to maintain sufficient health to participate in the school program.

Name of Medication _____
Prescribed Dosage and Time Schedule _____
Length of Time: _____ days, _____ months, _____ indefinitely
Diagnosis _____
Possible Side Effects _____

For Inhaler and Epi-Pen Medication Only

****Physician must initial one of the following:**

_____ It has been determined that this student is able to self-administer and carry inhalant medication or Epi-Pen and has been trained in it's use including knowing when the medication is to be used.

_____ This student should not self-administer inhalant medication or Epi-Pen.

Physician: Please note any necessary emergency response to be taken should an adverse reaction to inhalant medication occur. _____

Physician's Signature: _____ Date: _____

Physician's Name (Printed): _____

Address: _____

Telephone Number: _____

TO PARENTS:

I understand that:

- no medication will be administered without proper authorization.
- any change in medication, dosage, etc. requires new authorization.
- all medications should be turned in to the office/school nurse by the parent.

I do hereby release, discharge, and hold harmless the Connellsville Area School District, it's agents and employees, from any and all liability and claim whatsoever for the administration of the above medication.

Parents Signature: _____ Date: _____

Address: _____ Phone: _____