SLIPPERY ROCK AREA SCHOOL DISTRICT

Authorization for Medication(s)
Taken During School Hours

The following section is to be completed by the PARENT:

Student's Name_____
Last First Middle

School Name _____ **Grade**_____

Gender_____ **Birthdate**_____

Physician's Name_____
Address_____
_____Phone_____

I request that my child be assisted in taking the medicine(s) described below at school by authorized persons or permitted to self-medicate her/himself as also authorized by me and my physician (see below).

Parent Signature_____ Date_____
Home Phone _____Emergency Phone_____

The following is to be completed by the PHYSICIAN:

Diagnosis for which medication is given:_____

Name of Medicine	
Form	
Dosage	
If medicine is to be given **DAILY**, at what time?	
If medicine is to be given "**WHEN NEEDED**", describe medications	
How soon can it be repeated	
Is child qualified and authorized to self-medicate her/himself?	
List significant side effects	
Length of time this treatment is recommended	
Emergency Response	
Other Information	

Physician Signature_____Date_____

PLEASE NOTE THE FOLLOWING

1. Medication must be pharmacy bottle with a pharmacy label.
2. Bring a two weeks supply at one time – only for long term medication
3. Disposal of medication at the end of the school year. We need your permission to dispense this medication. Please sign here to give us permission to dispose of the medication.
4. All inhalers/epi pens on school property shall be labeled with student name and dosage – (Labels may be applied by school nurse.)
5. The school is not responsible for ensuring the asthma inhaler/epi pen is used properly when carried by the student, therefore the parent/guardian relieves the district and its employees of responsibility for the benefits or consequences of the prescribed medication.

_____
(PARENT'S SIGNATURE)

*** We will make an effort to return medications to your child**.