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_____ **Birthdate**_____
Last First Middle

School Name _____ **Grade**_____

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	
Is child qualified and authorized to carry & self-medicate her/himself? (inhaler, epi pen only)	
List significant side effects	
Length of time this treatment is recommended	
Emergency Response	
Choose an option below for field trips (required) _____ The prescribed dose can be withheld on the day of a field trip _____ The time can be adjusted with the parent/ guardian to be administered upon return to school _____ This medication must be given to the child at the prescribed time. Comments:	

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. Parents are responsible for checking expiration dates.
3. Medication not picked up by the parent/ guardian at the end of the school year will be disposed of. Medication must be picked up on or before the last day of school; school nurses are not available after that day.
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/epinephrine auto injector 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)

1/28/19