

WESTERN BEAVER COUNTY SCHOOLS
AUTHORIZATION FOR MEDICATION DURING SCHOOL HOURS

Student's Full Name: _____ may receive the following prescribed medication during school hours. It is our procedure to request that medication be given before or after school hours whenever possible. Schedule II drugs such as Ritalin, Adderall, etc. must be brought to the school by the parent/guardian or other adult (age 21 or older). Schedule II drugs MAY NOT BE TRANSPORTED BY ANY STUDENT.

Name of Medication _____ Prescribed Dosage _____

Time to be given: _____ Doctor Prescribing _____

Route of Administration (Oral, Injection, etc.) _____

Duration of medication administration: _____

Reason for medication: _____

Special instructions, if any: _____

Does the medication need refrigeration? _____ yes _____ no

Any curtailment of specific school activity? Explain: _____

Possible side effects and contraindications: _____

Procedure to follow if reaction should occur: _____

Other medications (prescription and non-prescription at school and home) the student is taking: _____

NOTE: If the dosage or time of the above medication changes, a doctor's note stating the change is required.

FOR THE PHYSICIAN

Physician's Signature _____ Date _____

Print Physician's Name _____ Phone _____

FOR THE PARENT/GUARDIAN

I give _____ I do not give permission for a staff member or teacher to administer my child's medication if he/she goes on a school field trip. Please note that only asthma inhalers and epi-pens which may be needed to avoid life-threatening situations will be sent on field trips.

I hereby authorize that the above medication is to be administered as stated above to my child or ward (name) _____ by the school nurse or designated person in her absence.

I release the Western Beaver County School District and all its employees from any liability for the administration of the above medication to my child or ward should there develop an allergic or other reaction from the medication.

I understand that all medication must be in the original pharmacy labeled container. (Pharmacies will provide you with a labeled container for school and another for at home.) I also understand that I or another adult must transport all Schedule II drugs to and from school.

DATE _____ PHONE _____

Parent/Guardian Signature _____