

Bellefonte Area School District

Authorization for Administration of Medication during School Hours

It is the policy of the Bellefonte Area School District to administer prescribed medication during school hours only when *absolutely* necessary. This medication must be provided in the original labeled pharmaceutical container and delivered to the school nurse by a parent or guardian.

To be completed by the Physician, PA-C, CRNP, or Dentist:

_____ must receive the following medication during school hours
(Student's Name and Date of Birth)
in order to maintain sufficient health and participate in the school program.

Diagnosis: _____

Medication: _____

Dose: _____ Time to be given: _____

Start Date: _____ Stop Date _____

Possible side effects: _____

Procedure to follow if reaction occurs: _____

The student is qualified to self-administer their asthma inhaler: Yes___ No___

The student is qualified to self-administer epinephrine for a serious allergic reaction: Yes___ No___

Physician/CRNP/PA-C/Dentist Name & Signature

Date

To be completed by Parent or Guardian

I hereby release Bellefonte Area School District and all of its employees from any and all liability in law for damages either I or my student may suffer as a result of this authorization. I give my permission for the school nurse or health room assistant to exchange information with my student's health care provider regarding this medication.

Parent/Guardian Signature

Date

All medication must be picked up on or before the last day of school. Any medication remaining beyond that day will be destroyed.

