ALLENTOWN SCHOOL DISTRICT HEALTH SERVICES
AUTHORIZATION FOR MEDICATION DURING SCHOOL HOURS

FOR THE PHYSICIAN:

Student Name: _____ must receive medication prescribed by me for the following condition:_____.

This medication must be given during school hours in order to maintain sufficient health and participation in the school program. Medication _____
Prescribed daily dosage _____
Time and dosage to be given in school _____
Duration period _____
Possible side effects _____

Permission is given to carry inhaler, epi-pen during school hours for middle and high school. ☐ Yes ☐ No
Does the child demonstrate knowledge of how to use inhaler, epi-pen for Middle and High School? ☐ Yes ☐ No

Date_____ Physician Signature:_____

Print Name of Physician _____ Phone Number _____

FOR THE PARENT OR GUARDIAN:

I give permission for the Allentown School District and/or their designee to administer the above medication to my child ***(Student Name)*** _____ as prescribed by the physician.

I agree to deliver medication to school in a labeled prescription bottle. The label must include the name of the medication, the prescribed dosage, the physician's name and the pharmacy.
I agree to deliver a new supply of medication to the school, as needed.
I authorize the Allentown School District to exchange health-related information with the above-named Physician.
I understand that a new medication authorization form must be completed by the parent and physician if the dosage is changed at any time.
Delayed School Openings – medication given on a schedule will NOT be given late at school when there is a delayed opening, but should be given at the scheduled time at home.
Field Trips – medication will not be sent on field trip unless specific arrangements have been made with the school nurse.
Emergency Procedures /Epinephrine – when anaphylactic symptoms are demonstrated, ASD emergency procedures, including the use of Epinephrine auto injectors, will be followed. Please contact your school's nurse with any concerns.
I agree to pick up my child's medication(s) the last day of school.

_____ _____
Date Parent(s) or Guardian(s) Signature

MEDICATION PICK UP.

Date picked up _____ Signature of parent(s) or Guardian(s)_____