School_____ Year_____

# SCHOOL DISTRICT OF THE CITY OF ERIE, PA.
# AUTHORIZATION FOR MEDICATION AT SCHOOL

Name of student_____ GR/HR_____

Name of medication_____

Diagnosis for which medication is given_____

Dosage_____ Time to be given_____

Can this medication be adjusted to accommodate class schedules?_____

If so, by how much?_____

If medication is to be given "PRN", describe indications and intervals_____

_____

List significant side effects_____

_____

Other prescribed medication_____

_____

Dates medication to be given_____ to _____

This medication has been prescribed by me and it is realized that the container MUST be clearly labeled with the name of the medication, the amount to be given, the time of day to be given and the duration of treatment. The parent is responsible for taking a periodic supply to the school to be dispensed by the appropriate professional school personnel, as so designated by the Erie School District. The medication is to be given in school because the medication must be taken at a time when the child is in school and another time is not feasible.

_____ _____

Physician's signature Physician's name printed

_____

Parent/guardian signature

*****THIS FORM MUST BE ACCOMPANIED BY THE RELEASE AND INDEMNITY AGREEMENT IN ORDER FOR MEDICATION TO BE GIVEN*****