Delta Elem Fax: 717-456-6042
Fawn Area Elem Fax: 717-382-1326
KDHS Fax: 717-382-4869
SEIS Fax: 717-382-4786
SEMS Fax: 717-382-9033
Stew Elem Fax: 717-993-5256

210-AR-2

SOUTH EASTERN SCHOOL DISTRICT

377 Main Street
Fawn Grove, Pennsylvania 17321

AUTHORIZATION FOR MEDICATION DURING SCHOOL HOURS

It is in the best interest of all concerned that medication be given before and after school hours whenever possible. If it is essential that your child receive medication(s) during school hours, the medication will be administered under the following conditions:

1. All medication(s) must be delivered to the health room or main office by a parent/guardian or other responsible adult. No medication will be dispensed until this completed form is received by the school. (A substitute form or note from the physician and parent will be acceptable if all the required information is provided.)
2. All medication(s) must be plainly marked with the student's name, name of medication, dose and time to be given. The original container for this medication is preferred. Bring to school only that amount which is required to be administered at school. Any medication left at school after date of last dose will be discarded.

TO BE COMPLETED and SIGNED BY *PHYSICIAN and PARENT/GUARDIAN* FOR PRESCRIPTION MEDICATION AND NON-PRESCRIPTION MEDICATION

Name of Student ____ Birth Date ____________________

Grade ________ Home Room ___________________

Medication ________________________ Reason for Medication/Diagnosis______________________________

Dosage ________ How to be Administered ____________ Time for Administration ____________

Date of First Dose _____________________ Date of Last Dose __________________________

Curtailment of School Activity, Side Effects or Contraindications ____________________________________

____

Medication may be held for field trip: ___ Yes or ___No.

If the morning medication dose is missed at home, the nurse may administer if confirmation is obtained. ___Yes ___No

Early dismissal days: Administer __________ Omit_________

Delayed opening days: Administer at usual time__________ Administer at alternate time of: ______________________

I certify that the above medication be administered during school hours.

Physician's Signature ____

Date Signed __________ Physician's Phone No. _____________________________

I give permission for the school nurse to consult with the prescribing physician about the medication ordered. This will confirm that I desire my student to receive medication during school hours as stated above. Intending to be legally bound hereby,
I do release, discharge and agree to indemnify and hold harmless the South Eastern School District, its agents, and employees, from any and all liability, loss, and claim of whatsoever nature resulting from the administration of the above medication to my child and from any and all illness or injuries resulting there from.

____ ______________________

Signature of Parent or Guardian Date

SESD revised 8/15