BETHLEHEM AREA SCHOOL DISTRICT
Bethlehem, Pennsylvania

AUTHORIZATION FOR MEDICATION DURING SCHOOL HOURS

Date: ______________________________

My child, ______________________________________, must receive the following prescribed medication during school hours in order to maintain sufficient health to participate in the school program. I will provide the medicine in an appropriately labeled, original pharmacy container.

Name of medication: ____

Prescribed dosage: ____

Time schedule: ____

Diagnosis <u>and</u> necessity of medication during schools hours: ___________________

____

Physician: ____

Student may self administer (rescue inhaler and epinephrine device only) _____________

Physician telephone number: ____

List side effects of medication: ____

____

Expected duration of medication regime: ____________________________________

Pharmacy: ____________________________ Pharmacy phone number: ___________________

<u>Field Trips</u> - Medication will not be sent on field trips unless specific arrangements have been made.

<u>School Delays or Early Dismissals</u> – In case of a delay or early dismissal, medications scheduled to be given during those times will not be given. Please call the school nurse with any questions or concerns.

I do hereby release, discharge and hold harmless, Bethlehem Area School District, its agents and employees, from any and all liability and claims whatsoever in connection with the administration of the above medication to my child.

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Signature of Parent or Guardian Signature of Physician

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BETHLEHEM AREA SCHOOL DISTRICT
Bethlehem, Pennsylvania

AUTORIZACION PARA ADMINISTRAR MEDICAMENTO DURANTE HORAS ESCOLARES

Fecha: ______________________________

Mi hijo/hija, ____________________________________, debe recibir el siguiente medicamento durante horas de clase ya que éste es necesario para que él/ella pueda hacer bien sus actividades escolares. El medicamento irá en el envase original de la farmacia y con la debida información en la etiqueta:

Nombre del medicamento: ____

Dosis recetada: ____

Horas en que se administrará: ____

Nombre del médico: ____

El estudiante puede auto administrarse (el inhalador rescatador y el dispositivo de epinefrina solamente) _____________

Telefono del médico: ____

Efectos secundarios o reacciones del medicamento: _________________________

____

____

Diagnosis y razón por la que debe administrarse en la escuela: ________________

____

Por cuánto tiempo debe administrarse: ____________________________________

____

Por este medio, yo relevo al Distrito Escolar, sus agentes y empleados de toda responsabilidad en lo que respecta a la administracion del medicamento en la escuela.

Si su niño/a va a ir a un viaje escolar, no ilevará la medicina consigo si no se han hecho arreglos de antemano.

________________________________ ________________________________

Firma del Padre o Encargado Firma del Médico

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