NOTRE DAME SCHOOLS

EAST STROUDSBURG AREA SCHOOL DISTRICT

AUTHORIZATION FOR MEDICATION DURING SCHOOL HOURS/SCHOOL ACTIVITIES

IMPORTANT: This form must accompany any/all medications brought to school. It must be completed whenever any medication must be given to a student during school hours in order to maintain sufficient health to remain in school. **Medication must be packaged in the properly labeled pharmacy container.**

No medication of any kind can be dispensed/given to your child at school without the written physician authorization provided through the proper completion of this form. No exceptions will be made. Written permission from parents cannot be accepted.

PHYSICIAN USE ONLY
PHYSICIAN AUTHORIZATION

Student_____ Age_____ Grade_____

Medication_____ Dose_____

Time Schedule_____

Duration (Days, Weeks, School Term)_____

Diagnosis_____

Special Instructions/Conditions to Observe_____

_____

_____ _____
(Date) (Physician's Signature)

( )_____ _____
(Phone Number) (Printed Physician's Name)

_____
(Physician's Address)

FOR PARENT/GUARDIAN USE

I authorize the Notre Dame Schools to administer the above medication as prescribed. I give permission for exchange of verbal and written communication between the physician and school nurse regarding my child's medication regimen. I do hereby release, discharge and hold harmless the Notre Dame Schools, its agents and employees, from any and all liability and claim whatsoever for the administration of the above medication to my child should they develop a reaction from the medication. I understand that the medication must be in a properly labeled pharmacy container. I understand that the Notre Dame Schools bear no legal responsibility for the benefits or consequences of the administration of the medication.

_____ _____
(Signature of Parent/Guardian) (Date)