

Avella Area School District
1000 Avella Road
Avella, PA 15312

Authorization For Prescription And Nonprescription
Medication During School Hours

Name: _____

Date: _____ Age: _____ Grade: _____

_____ (full name of student) must receive the following medication during school hours in order to maintain sufficient health to participate in the school program.

Name of Medication: _____

Prescribed Dosage: _____

Time Schedule: _____

Length of Time (Days/Weeks): _____

Reason for Medication: _____

Other Medications Being Taken or Prescribed: _____

Possible Side Effects: _____

Instructions for Use: _____

If Inhaler or Epi-Pen, is the student to carry? YES NO

*(If the student is to carry one, it is strongly recommended that an extra be given to the school nurse)

Any Curtailment of Activity? _____

List Any Other Medications Child is Taking: _____

I do hereby release, discharge and hold harmless – the Avella Area School District, it's agents and employees, from any and all liability and claim whatsoever for the administration of the above medication to my child/ward should there develop an allergic or other reaction from the medication.

PARENT/GUARDIAN SIGNATURE

PHYSICIAN'S SIGNATURE