

EAST STROUDSBURG AREA SCHOOL DISTRICT
East Stroudsburg, Pennsylvania 18301

AUTHORIZATION FOR MEDICATION DURING SCHOOL HOURS/SCHOOL ACTIVITIES

*****IMPORTANT NOTICE TO ALL PARENTS:**

Please remember.....**NO MEDICATION OF ANY KIND** can be dispensed/given to your child at school without a **WRITTEN ORDER** (*see below) **FROM A PHYSICIAN**. It is your responsibility to ask your physician for a completed form or take the sample below with you.

*****NO EXCEPTIONS WILL BE MADE - WRITTEN PERMISSION SLIPS FROM PARENTS CANNOT BE ACCEPTED.** Thank you for your cooperation.

PHYSICIAN AUTHORIZATION

THIS FORM MUST ACCOMPANY ANY/ALL MEDICATIONS BROUGHT TO SCHOOL

This form 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.

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 Name)

Address _____

PARENT/GUARDIAN AUTHORIZATION

I authorize the East Stroudsburg Area District to administer the above medication as prescribed. I do hereby release, discharge and hold harmless the East Stroudsburg Area School District, 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 any allergic reaction from the medication.

(Date)

(Signature of Parent/Guardian)