

**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 East Stroudsburg Area School District 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 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 a reaction from the medication. I understand that the medication must be in a properly labeled pharmacy container. I understand that the East Stroudsburg Area School District bears no legal responsibility for the benefits or consequences of the administration of the medication.

_____ (Signature of Parent/Guardian)

_____ (Date)

**EAST STROUDSBURG AREA SCHOOL DISTRICT
AUTHORIZATION TO CARRY/SELF-ADMINISTER PRESCRIBED MEDICATION**

(Student to carry copy of this document at all times. Original to be on file in School Nurse's Office)

**FOR PHYSICIAN USE ONLY
PHYSICIAN AUTHORIZATION**

Student _____ DOB _____ Grade _____

Medication and dose _____

Time of or circumstances requiring self-administration _____

Diagnosis _____

Possible side effects/conditions to observe _____

IN MY OPINION, THIS STUDENT SHOWS THE CAPABILITY TO CARRY AND SELF-ADMINISTER THE ABOVE-NAMED MEDICATION.

(It is preferable that additional prescription labeled medication be kept in the School Nurse's Office in case the first is left at home or lost)

Duration of authorization [maximum one (1) school year] _____

Physician's signature _____ Date _____

Printed physician's name _____ Phone _____

Address _____

FOR STUDENT USE

I have been instructed in the proper use of my prescribed medication and fully understand how and when to use it. I will use this medication only according to the above instructions from my doctor. I will not share this medication under any circumstances. I understand that, should another student use my medication, the privilege of carrying my medication with me may be taken away. I will immediately report lost or missing medication. I also agree to come directly to the school nurse, a teacher, a coach, an athletic trainer or a principal after using my medication in order to report its use.

Student signature _____ Date _____

FOR PARENT/GUARDIAN USE

I request that my child (named above) be permitted to carry/self-administer the above medication as per the order of the physician. I understand that the medication must be in a properly labeled pharmacy container. I understand that I, the parent/guardian, accept the legal responsibility should the above medication be lost, given to, or taken by a person other than the above-named student. I understand that the East Stroudsburg Area School District has no legal responsibility to ensure that the medication is taken or when the above-named student administers his or her own medication and bears no responsibility for the benefits or consequences of the administration of the medication.

Parent/Guardian signature(s) _____ Date _____

FOR SCHOOL USE

We accept the above physician's order, student's statement, and parent/guardian request. We will permit the above-named student to carry/self-administer the prescribed medication. We reserve the right to take appropriate action, which may include withdrawing this privilege, if the student shows signs of irresponsible behavior or if there is a safety risk.

Principal _____ Date _____

School Nurse _____ Date _____

**EAST STROUDSBURG AREA SCHOOL DISTRICT
AUTHORIZATION FOR BLOOD GLUCOSE MONITORING AND MEDICATION DURING
SCHOOL HOURS FOR THE DIABETIC STUDENT**

**FOR PHYSICIAN USE ONLY
PHYSICIAN AUTHORIZATION**

Name _____ Date _____

1) Check blood sugar daily
a) Before lunch
b) PRN for symptoms
c) Other time(s) _____

2) Lunchtime dose of Humalog insulin is _____

3) Treat low blood sugar (less than _____) with _____

4) Administer Glucagon _____ mg IM prn for severe hypoglycemia

5) Treat high blood sugars (above _____) with humalog insulin as follows:

6) Check for urine ketones above _____. Treatment for ketones _____

7) Special instructions: (gym, after school, etc.): _____

Physician Signature _____

Printed Physician Name _____

Address _____

Phone _____ FAX _____

FOR PARENT/GUARDIAN USE

I authorize the East Stroudsburg Area School District (ESASD) to administer the above medications as prescribed. I do hereby release, discharge and hold harmless the ESASD its agents and employees, from any and all liability and claim whatsoever for the administration of the above medications to my child should he/she develop an adverse reaction from the medication.

(Signature of Parent/Guardian)

(Date)