POCONO MOUNTAIN SCHOOL DISTRICT

Authorization for Medication During School Year

Date_____

My child, _____, must receive the following, prescribed or over the counter medication during school hours, and school sponsored activities in order to maintain sufficient health to participate in the educational process. I will provide the medicine in an appropriately labeled, original, pharmacy container.

Physician/Provider, please complete form below:

Name of medication_____

Dosage_____For school year_____

Time schedule_____

Diagnosis_____Side effects of medication_____

The student is capable of carrying inhaler or epinephrine & may self-administer if needed. Please circle one: Yes or No

Medication during school sponsored activities:

- ___Will be omitted on the day(s) of the field trip.
- ___Will be administered by a parent/designated guardian accompanying the student on the field trip
- ___Will be administered prior to leaving the school or upon return to the school.

Physician name (please print) & phone number_____

Pharmacy_____Pharmacy phone number_____

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

_____ _____

Signature of Parent/Guardian Signature of Physician