

THE ARTS ACADEMY CHARTER SCHOOL
AUTHORIZATION FOR MEDICATION ADMINISTRATION

To the Physician:

Schools in Pennsylvania may administer medication to a child only under orders of a physician. This applies to both prescription and over-the-counter drugs. Please complete this form if you wish your patient to receive medication during school hours.

Student's Name _____ Grade _____

Medication prescribed _____

Prescribed dosage and frequency _____

Time of day _____

Reason for medication _____

Does medication require refrigeration? _____

Precautions _____

Side-effects _____

Is child taking any other medication(s)? _____

Name of other medication(s) _____

It is my understanding that the employees of the Arts Academy Charter School charged with the dispensing of medication may rely upon my directions as contained in this form to dispense the medication which I have prescribed for:

Student's Name _____

The authorization shall be in effect from _____, 20__ to _____, 20__. I certify that I am the physician who prescribed the above medication and that the student who is to receive the medication is under my care. I further certify that it is imperative that the medication prescribed be taken during school hours.

Date _____ Signature of Physician _____

Print Name of Physician _____

Address of Physician _____

Phone Number of Physician _____

Emergency Number of Physician _____

To the Parent: **MEDICATION MUST BE SENT IN ITS ORIGINAL CONTAINER.** I DO HEREBY RELEASE, DISCHARGE, AND HOLD HARLESS, The Arts Academy Charter School

its agents, and employees from any and all liability and claim of whatsoever nature for the administration of the above medication to my child any for any and all injury resulting there from.

Signature of Parent/Guardian _____

Date _____