PALMERTON AREA SCHOOL DISTRICT
SCHOOL HEALTH SERVICES

AUTHORIZATION FOR MEDICATION

My child, _____, may receive the following medication during school hours.

1. Medication Name _____
2. Reason for Medication _____
3. Route _____
4. Prescribed Dosage _____
5. Time of Administration _____
6. Side Effects _____
7. Discontinue Date _____
8. Allergies _____
9. Other Medication Child is Taking_____
   _____
10. Physician Signature _____
11. Physician Printed Name _____
12. Physician Address _____
13. Physician Phone Number _____

*All medications must be brought in by a parent/guardian and be in the original containers.
*I do hereby release, discharge and hold harmless, Palmerton 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, nor shall said school district be held accountable to the development of any reaction from the administration of such medication.
*This authorization must be renewed each school year.

_____

Signature of Parent or Guardian

Printed Name of Parent or Guardian

_____

Witness

_____

Date