Elizabethtown Area School District

Medication Authorization and Information Form

Dear Parent or Guardian:
The administration of medication during the school day is sometimes unavoidable. The medication policy of the Elizabethtown Area School District states that before any medication, prescribed or over-the-counter, may be administered to or by any student during school hours, a **signed written order from the prescribing medical provider and the written request of the parent/guardian**, giving permission for such administration, is required. Only medication accompanied by the information requested on the Medication Authorization Form will be administered during school hours.

To provide a safe environment for all students, **every medication must be brought to school by a parent or guardian** and taken to the Nurse's Office immediately upon entering the building. The Nurse's Office can only accept a 30-day supply of any one medication. All medication, whether prescribed or over-the-counter, must be received in the original container in which it was dispensed.
Any change to the prescribed order requires the completion of a new form.

Thank you for your cooperation,
The Elizabethtown Area School District

Request For Medication During School Hours

To be completed by Physician, Nurse Practitioner, or Physician's Assistant:

_____ _____ _____ _____
Name of Student D.O.B. Teacher/Grade Date

_____ _____ _____
* Name of Medication Dosage/ Unit Route

_____ _____ **or *Remainder of School Year***
Time Medication is to be Administered Number of Days to be Administered

_____ _____
Reason/Purpose Possible Side Effects

***Inhaler Use**: This student was taught and has demonstrated competence with self-administering his/her inhaler and responsible behavior in the use of the medication. He/she has permission to carry and self-administer his/her inhaler, as prescribed, when needed. *The student shall notify the nurse or designee immediately following each use.* If the student abuses or ignores the school policies, the privilege to carry the medication will be reviewed by school administration.

Provider Initials _____ _____
Yes No

_____ _____
Physician/NP/PA Signature **Printed Name**

_____ _____
Phone# Date

*Signing verifies that the above plan has been prescribed by you, the child's physician, and should be carried out by the school he/she attends.

_____ _____
Signature of Parent/Guardian **Printed Name**

_____ _____
Phone# Date

**Signing verifies that you, the parent/guardian, give permission for the school staff to carry out the administration of the above prescribed plan in your absence and relieve the Board and its employees of responsibility for the benefits or consequences for such medication and its administration.

Rev. 3/17

Elizabethtown Area School District

Medication Authorization and Information Form

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