HOLLIDAYSBURG AREA SCHOOL DISTRICT MEDICATION AUTHORIZATION FORM

TO BE COMPLETED BY PARENT/GUARDIAN

Student Name: ______________________ Grade: ________ Date of Birth: ____________

School: ______________________ School Year: ____________

I give permission for (child name) ______________________ to receive the stated medication at school according to school medication policy. I release the Hollidaysburg Area School District and its employees from any claim or liability for administering prescribed medication to this student. I HAVE READ THE INFORMATION OUTLINED ON THE BACK OF THIS FORM AND ASSUME THE RESPONSIBILITIES AS STATED ON THIS FORM. I authorize the school nurse to communicate with the health care provider as allowed by HIPAA.

Signature: ______________________ Relationship: ______________ Date: __________

Home Phone: ______________ Work Phone: ______________ Emergency Phone: ______________

TO BE COMPLETED BY PHYSICIAN, DENTIST, CRNP, PHYSICAN ASSISTANT

I authorize the school nurse, substitute school nurse, or parent volunteer nurse/physician if on a field trip to administer the following medication:

Student Name: ______________________ Age: __________

Name of Medication: ______________________ Allergies: ______________________

Dosage/Route: ______________________

Reason for Medication: ______________________

Time to be given at school: ______________________

If PRN, for what symptom(s): ______________________

Side effects: ______________________

Discontinue(Please check one): __________ end of school year, or __________ other (list date): ______________

Authorized Prescriber's Signature: ______________________ Date: __________

**** For Self-Administration ONLY ****

TO BE COMPLETED BY PHYSICIAN FOR EMERGENCY MEDICATION (e.g. Inhaler, Epipen) ONLY

Hollidaysburg Area School District permits a student to possess and self-administer emergency medication at school and at school-related functions. Completion of the following information by the authorized prescriber acknowledges that this student has been instructed and has the skills and knowledge on self-administration of this medication.

This student may carry this medication: ________ YES ________ NO

Authorized Prescriber's Signature: ______________________ Date: __________

TO BE COMPLETED BY THE STUDENT (FOR ASTHMA INHALER OR EPIPEN ONLY)

I acknowledge that I have been instructed by my medical care provider on the proper use of my inhaler/Epipen. I agree to be solely responsible for my inhaler/Epipen and to follow the directions for its use as ordered by my physician, as well as the district's medication policy. I am aware that any abuse of this privilege will result in the confiscation of my inhaler/Epipen.

Student's signature: ______________________ Date: __________

PLEASE SEE REVERSE SIDE FOR FAX NUMBERS AND GUIDELINES

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