WILKES-BARRE AREA SCHOOL DISTRICT

AUTHORIZATION FOR MEDICATION DURING SCHOOL HOURS

Please print **Date**_____

Student **Last Name** _____ **First name** _____ Grade___ Sec.____

Must receive the following medication during school hours in order to maintain sufficient health to participate in the school program.

Address_____

Home Phone_____ Cell Phone _____Work Phone_____

PHYSICIAN AUTHORIZATION

Name of Medication_____

Prescribed dosage_____

Time to be given_____

Diagnosis and necessity of medication during school hours_____

_____

Expected duration of medication regime_____

Allergies (medicines/foods)_____

Physician's Signature_____Date_____

Physician's Printed Name: _____

I hereby release, discharge and hold harmless, Wilkes-Barre Area School District, its agents and employees, from any and all liability and claims whatsoever in connection with the administration of the above medication to my child.

Parent/Guardian Signature: Date: