



TULPEHOCKEN AREA SCHOOL DISTRICT
27 Rehrersburg Road Bethel, PA 19507

Bethel Elementary (717) 933-4131 FAX (717) 933-8485
Penn-Bernville Elementary (610) 488-6248 FAX (610) 488-1188
Tulpehocken Jr./Sr. High School (610) 488-6286 FAX (610) 488-7976

**AUTHORIZATION FOR SCHOOL MEDICATION ADMINISTRATION
(FORM MUST BE COMPLETED IN ITS ENTIRETY)**

Child's Full Name: _____ Grade/Homeroom: _____

Date of Birth: _____ Drug Allergies: _____

PHYSICIAN'S REQUEST

Name of medication: _____

Reason: _____ Route: _____

Side effects and/or limitations on activities: _____

Time and dose(s) to be given at home: _____

Time and dose(s) to be given at school: _____

Medication is to be administered:

1. _____ until completed. Dates to be given at school: _____
2. _____ entire school year. Daily _____ PRN _____
3. _____ other: _____

_____ I believe this child is able and responsible to carry and self-administer his/her inhaler (grades K-12) and/or Epi-Pen (grades 7 - 12) during school. He/she has permission to do so and has been instructed on how to self-administer.

Physician's Signature

Printed Name

Date

Phone Number

PARENT'S REQUEST

I, the parent/guardian of _____ request that the employees (nurse, principal, or principal designee) of the Tulpehocken Area School District administer the above named medication as prescribed by my child's physician. My signature on this document constitutes a complete waiver of liability claim in any and all respects against the Tulpehocken Area School District and its Board of Directors and all employees unless the District is negligent with regard to any claim for injury in connection with administration of the medication.

Additionally, **I agree to hand deliver** the medication to the nurse's office in the original pharmacy or physician labeled container. I also accept responsibility to provide a physician's note and my written instruction if the medication is to be changed or discontinued. I give permission for the school and physician to communicate regarding this medication and medical condition.

_____ I believe my child is able and responsible to carry and self-administer his/her inhaler (grades K-12) and/or Epi-Pen (grades 7 - 12) during school activities. I give my permission for him/her to do so and he/she has been instructed on how to self-administer.
If my child uses his/her inhaler or Epi-Pen, he/she will notify the nurse as soon as possible after using the medication.

Parent/Guardian Signature

Date

List all medications currently being taken by this child: _____