Mid Valley Secondary Center

52 Underwood Road * Throop, PA 18512

Chad Vinansky, Supervisor of Student Services *(570) 307-1150*

Authorization for Medication During School Hours

Important notice to Parents/Guardians:

Please remember, as per State law, no medication of any kind can be dispensed or self –administrated by your child at school without a written physician's order. Unfortunately, written permission slips from parents cannot be accepted. Thank you for your cooperation.

Physician Authorization

Medication must be packaged in the original or properly labeled pharmacy container with no more than a two week supply.

Student Name:_____ Age: _____ Grade: _____

Homeroom Teacher: _____

Medication: _____ Dose: _____

Form of Medication/Treatment: (*check below*)

Tablet/Capsules ⬭ Liquid ⬭ Inhaler ⬭ Injection ⬭ Nebulizer ⬭ Other: _____

Time Schedule: _____ Storage Requirements: _____ None _____Refrigerate

Duration (day, weeks, school term) _____ Diagnosis: _____

This student is both capable and responsible for self-administering this medication:

⬭ NO ⬭ Yes, with supervision ⬭ Yes, unsupervised, student may carry medication

Special instructions/Conditions to observe: _____

Restrictions and/or important side effects: ⬭ NONE anticipated

⬭ Yes, please describe, _____

_____

_____

Physician's Name (PRINTED): _____

Physical address of Physician's office: _____

Physician Signature: _____ Date: _____

Office Phone Number: _____

PLEASE INDICATE IF YOU HAVE PROVIDED ADDITIONAL INFORMATION:

⬭ On the back side of the form ⬭ As an attachment

Parent Signature: _____ Date: _____

Mid Valley Secondary Center

52 Underwood Road * Throop, PA 18512

Parent/Guardian Authorization

I authorize the Mid Valley School District to administer/or monitor the self-administration of the medication as prescribed above. I do hereby release, discharge and hold harmless the Mid Valley School District, its agents and employees, from any and all liability and claims whatsoever for medication administration/or the supervision of self-administration. I understand that the Mid Valley School District will not assume responsibility for the medication that is lost, stolen or left at home.

Signature of Parent/Guardian: _____ Date: _____

Signature of Certified School Nurse: _____

Reviewed by Certified School Nurse on _____