Seven Generations Charter School
Emmaus, Pennsylvania

Authorization for Medication During School Hours

Date: _____

My child, _____, must receive the following prescribed medication during school hours in order to maintain sufficient health to participate in daily school activities. I will provide the medicine in an appropriately labeled, original pharmacy container.

Name of medication: _____

Prescribed dosage: _____

Time schedule: _____

Healthcare provider: _____

Provider's phone number: _____

Pharmacy: _____

Pharmacy's phone number: _____

List side effects of medication: _____

Expected duration of medical regime: _____

Diagnosis and necessity of medication during school hours: _____

If the student may carry and be responsible for an Epipen or metered dose inhaler, please initial here:

_____ Prescriber _____ Date

_____ Parent _____ Date

I do hereby release, discharge, and hold harmless, Seven Generations Charter School, its agents and employees, from any and all liability and claims whatsoever in connection with the administration of the above medication to my child.

Medication will not be sent of field trips unless specific arrangements have been made. The school nurse does not accompany students.

_____ _____

Signature of Parent Signature of Healthcare Provider