BROWNSVILLE AREA SCHOOL DISTRICT

5 FALCON DRIVE

BROWNSVILLE, PA 15417

REQUEST FOR ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS

The Brownsville Area District requests that medication be administered at home during non-school hours. We do, however, recognize that sometimes it is essential for medication to be administered at school. No prescription or "over-the-counter" medications will be given to any student without an order from a physician, along with signatures from the physician and the parents/guardian. All medication MUST be in the original manufacturer's container with the student's name written on the container. All prescription medications MUST be in a pharmacy labeled container. The pharmacy labeled container must include the name and phone number of the pharmacy, the name of the student, the physician's name, the name of the medication, the currently prescribed dose, time of administration and the Rx number.

Student's Name

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First Last School Grade

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Physician's Name (print) Phone Number/Fax Number

I understand fully the directions that have been given to the school by the physician and agree to permit the school to administer this medication to my child. In consideration of the school district's agreement to use good faith efforts to properly administer this medication, the district is hereby relieved from liability for any failure to properly administer this medication. I hereby authorize the Brownsville Area School District and its Designees to administer the above listed medication to my child and/or charge named. I release The Brownsville Area School District and its designees of any and all responsibility for problems arising from the administration of the above named medication to my child and/or charge. I state that I have complied with all of the provisions as stated in the administrative medication policy. I also authorize the school to contact the physician regarding said medication.

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Parent/Guardian Signature Phone Number (home/cell/work) Date

TO BE COMPLETED BY THE PHYSICIAN:

Name of Medication:	
Diagnosis (reason medication is prescribed):	
Dose:	**Route:**
Time of administration :	
List Significant side effects: **Please state if student is permitted to carry and self-administer:**______________________	
______________________ Physician Signature	Date