NEW BRIGHTON AREA SCHOOL DISTRICT
3225 43RD STREET - NEW BRIGHTON, PA 15066
Elementary School 843-1194 | Middle School 846-9100 | High School 846-1050

K-12 HEALTH SERVICES

AUTHORIZATION FOR SHORT TERM MEDICATION DURING SCHOOL HOURS

(This Form Must Accompany Medication Administered During School Hours)

Please send a single daily dose of prescribed medication in a protective container which is properly labeled with: **Name of Student, Name of Medication, Dosage, and Time for Dispensing.**

Short term prescriptions must be resubmitted every two weeks.

PHYSICIAN'S MEDICATION REQUEST

_____ must receive the following
Student's Name Grade

prescribed medication during school hours in order to maintain sufficient health to participate in the school program:

Name of medication _____

Prescribed dosage _____

Time Schedule _____

Length of time (days/weeks) _____

Reason for administration _____

Possible side effects _____

_____
Signature of Physician Date

NOTE: A copy of the doctor's prescription may be substituted for above form.

I do hereby release, discharge, and hold harmless the New Brighton Area School District, its agents, and employees from any and all liability and claim whatsoever for the administration of the above medication to my child/ward. I understand I must provide physician's signature for the above medication.

_____
Signature of Parent/Guardian Date