NEW BRIGHTON AREA SCHOOL DISTRICT
3225 43rd Street, New Brighton, PA 15066

K - 12 HEALTH SERVICES

AUTHORIZATION FOR DISTRIBUTING MEDICATION DURING SCHOOL HOURS

(This Form Must Accompany All Medication)

Parents/Guardians are to send a single daily dose of medication in the original prescription container labeled with: name of child; name of medication; dosage; name of physician and date.

MEDICATION REQUEST FORM

________________________________ must receive the following medication
Student's Name Grade

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

Name of medication ________________________________

Prescribed dosage ________________________________

Length of time (days/weeks) ________________________________

Reason for administration ________________________________

Possible side effects ________________________________

Name of physician ________________________________

Signature of Physician ____________________ Date __________

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 prescribed medication.

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Signature of Parent/Guardian Date

	Elementary School	Middle School	High School
Phone #	724-843-1795 x1	724-843-1795 x2	724-843-1795 x3
Fax #	724-843-8769	724-846-2337	724-846-2204