UNIONVILLE-CHADDS FORD SCHOOL DISTRICT

AUTHORIZATION FOR PRESCRIPTION MEDICATION DURING SCHOOL HOURS

No more than a thirty (30) school day supply for any one medication should be stored at school.

_____ must receive the following PRESCRIBED MEDICATION
Full Name of Student
during school hours in order to maintain sufficient health for participation in the school program:

Name of Medication _____

Prescribed Dosage _____

Time Schedule _____

Length of Time (days/weeks) _____

Reason for Administration* _____

Possible Side Effects _____

_____ _____
Date Signature of Medical Practitioner

I do hereby release, discharge, and hold harmless the Unionville-Chadds Ford School District, its agents and employees, from any liability and claim whatsoever for the administration of the above medication to my child/ward should there develop an allergic or other reaction from the medication.

_____ _____
Date Signature of Parent/Guardian

***Emergency medications, i.e. inhalers and EpiPens may be carried by school age students with parent/guardian's and medical practitioner's permissions.**

_____ **has permission to carry and self-administer this**
Full Name of Student prescription medication.

_____
Signature of Parent/Guardian Date

_____**has demonstrated the ability and is qualified to safely self-**
Full Name of student administer this prescription medication.

_____
Signature of Medical Practitioner Date