SAINT CORNELIUS CATHOLIC SCHOOL

AUTHORIZATION FOR PRESCRIPTION MEDICATION DURING SCHOOL HOURS

(A signed doctor's note on their letterhead must accompany this form)

_____ must receive the following
Full Name of Student (please print)

PRESCRIBED MEDICATION 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, Doctor, or P.A.

I do hereby release, discharge, and hold harmless the Unionville-Chadds Ford School District and the Archdiocese of Philadelphia, 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 prescription medication.**
Full Name of Student

_____
Signature of Parent/Guardian **Date**

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

_____
Signature of Medical Practitioner **Date**