

# Fairlawn Local Schools

## Authorization for Administration of Medication During School Hours

It is the policy of Fairlawn Local School District to administer prescribed or non-prescribed medication during school hours only when absolutely necessary. This medication must be provided in the original labeled pharmaceutical container or manufactured labeled container and delivered to the school nurse.

**\*\*Physician or Dentist signature required for prescription medication\*\***

Student's Name: \_\_\_\_\_ must receive the following medication during school hours in order to maintain sufficient health to participate in the school program.

Diagnosis: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Time to be given: \_\_\_\_\_

Route: \_\_\_\_\_

Duration of order: \_\_\_\_\_

Possible side effects: \_\_\_\_\_

Procedure to follow if reaction occurs: \_\_\_\_\_

\_\_\_\_\_  
Medical Provider Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Medical Provider Name (Printed)

\_\_\_\_\_  
Phone Number

### Parent or Guardian Section to Complete:

I do hereby give consent for my child to receive the above ordered medication and release the Philipsburg-Osceola 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, should there be an allergic or other reaction from the medication. I understand that I am responsible for any mishandling of medication if transported by my child.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date