# CONEMAUGH TOWNSHIP AREA SCHOOL DISTRICT

**Authorization for Prescription or Non-Prescription Medications to be taken during school hours and Authorization for Release of Medical Information**

- This form must be submitted for each medication, both prescription and non-prescription
- Prescription medication must be in a container and labeled by the pharmacy with the following information:
  Student Name, Physician Name, Date of Prescription, Name & Phone Number of Pharmacy, Name & Dosage of Medication
- Non-prescription medication must be in the original container
- Parents must notify school personnel if a medication is discontinued
- A new form must be submitted for any dosage or time change
- A new form must be submitted at the beginning of each school year for medications taken during school hours
- It is the responsibility of the student to report to the office to receive medication

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**PARENT TO COMPLETE THIS SECTION**

Student Name _____ School Name_____

Date of Birth_____Sex_____Grade_____

Physician Name_____ Physician Phone_____

**I request my child be permitted to medicate herself/himself as authorized by me and my physician, or be assisted in taking the medication described below at school by authorized persons.**

In consideration of Conemaugh Township Area School District granting our request to dispense certain medication to our child and/or allow self administration of medication, the undersigned parents, on our own behalf of our minor child, hereby release, indemnify, and hold harmless Conemaugh Township Area School District and its School Board, Administrators, and Nurses from and against any and all claims, damages, actions, or causes of action resulting, arising out of or connected directly or indirectly with the request for or the dispensing of the medication listed below to our said child.

**I understand and agree that any medical information may be shared with appropriate school and medical personnel.**
**I authorize my physician to release any medical information that may be requested by district personnel.**

Signature of Parent/Guardian _____Date_____

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**PHYSICIAN TO COMPLETE THIS SECTION**

Diagnosis for which medication is given_____

Name of prescription or non-prescription medication_____

Dosage_____Route_____Time_____

If medication is to be given WHEN NEEDED, describe indications_____

Is student authorized to medicate herself/himself? _____

Side effects or precautions_____

Duration of medication_____

Special instructions_____

**SIGNATURE OF PHYSICIAN_____DATE_____**