SYLVAN HEIGHTS SCIENCE CHARTER SCHOOL

Phone 232-9220 Fax 232-9221

AUTHORIZATION FOR MEDICATION DURING SCHOOL HOURS

This form must be completed whenever any medication must be given to a student during school hours in order that a continuous medication regime is maintained. Medication must be packaged in the properly labeled pharmacy container.

To the Physician:

_____ _____Sylvan Heights Science Charter School
Student Last Name/First Name D.O.B

Diagnosis: _____

Medication and dosage: _____

Route of administration (oral, injection, etc.) _____

Time schedule: _____

Duration of administration (days, weeks): _____

Possible side effects: _____

Other medications student is taking: _____

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Date: _____ Physician's Name: _____

Physician's Signature: _____Phone: _____

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To the Parent:

I authorize Sylvan Heights Science Charter School to administer the above medication as prescribed. I so hereby release, discharge and hold harmless the Sylvan Heights Science Charter School, its agents and employees, from any and all liability and claim whatsoever for the administration of the above medication to my child.

Date: _____ _____
Parent/Guardian Signature