Northwestern Lehigh School District
MEDICATION AUTHORIZATION

ALL MEDICATIONS MUST BE REGISTERED IN THE NURSE'S OFFICE.

School Year: _____

NAME OF STUDENT_____TEACHER/GRADE _____

MEDICATION _____ Dosage: _____

Condition or Reason: _____

Time Schedule: _____ Possible Side Effects: _____

Any special instructions: _____

SIGNATURE OF PARENT/GUARDIAN _____

SIGNATURE OF PHYSICIAN: _____

Date: _____

- I do hereby grant permission for the school staff to communicate with the student's physician.
- I do hereby release, discharge, and hold harmless Northwestern Lehigh School District and its employees from any and all liability and claims whatsoever in connection with the administration of medication to my child.
- I have read and agreed to follow the procedures set forth by the policy, and authorize the School Nurse, or designee, to administer medication.

Asthmatic/Allergy Students

Student (Grade 7-12 only) may carry his/her own inhaler/Epi-pen to use as medically necessary without supervision. YES_____ NO _____

PARENT SIGNATURE: _____

Student (Grade K-6) May carry his/her own inhaler/Epi-pen to use as medically necessary with below statement **(*)** signed by Physician.

***This child is qualified and able to self-administer his/her own inhaler/Epi-pen**.

PHYSICIAN'S NAME (print): _____

SIGNATURE OF PHYSICIAN: _____

PHYSICIAN'S PHONE NUMBER: _____

Physician signature is required for all controlled substances and prescriptions as defined by the Medication Policy.

Date	Action	Quantity	Nurse Initials	Parent Signature