THE LEHIGH VALLEY CHARTER HIGH SCHOOL FOR THE ARTS
Healthroom

(LVPA — The Lehigh Valley Charter High School for
www.C
675 East Broad Street, Bethleh
phone 610-868-2971 ext 136 | fax 610-868-1663 | nurse@C

AUTHORIZATION FOR PRESCRIPTION MEDICATION ADMINISTRATION

DURING SCHOOL HOURS

Date:

My Child _must receive the following Prescribed Medications during School Hours in order to maintain a sufficient Health Status in order to fully participate in the Educational Process:

Have the Prescriber (MD,DO, CRNP) complete the following or attach a Written Prescription:

Name of Medication:

Dose:

Time Schedule:

Purpose of medication: _____

Name of Presciber (MD,DO, CRNP):

Prescriber Phone Number:

Has the Child experienced Side Effects from this Medication? If so, please list:

Is it Medically Necessary for this Medication to be administered during the School Hours?

If the Student may Carry and is Proficient in Administering and will be Responsible for Epi-Pen or Metered Dose Inhaler, please Initial here: _____Prescriber_____Date _____Parent____Date

Signature of Prescriber (MD, DO, CRNP)

I do hereby Release, Discharge and Hold Harmless the Lehigh Valley Charter High School for the Arts, and their Agents and Employees from any and all Liability and Claims in connection with the Administration of the Named Medication to my Child. **Medication will not be sent on field trips unless specific arrangements have been made. School Nurses do not accompany Students. The above information may be shared with Appropriate Personnel on a Need –To- Know Basis. The Health Staff of Charter Arts may contact the Medical Provider for any clarification or concerns regarding the above Prescribed Medication.**

_____

Name of Parent or Legal Guardian (print)

_____ Date: _____

Signature of Parent or Legal Guardian