THE LEHIGH VALLEY CHARTER HIGH SCHOOL FOR THE ARTS

www.CharterArts.org

321East 3rd Street, Bethlehem, PA 18015
phone (610) 868-2971 | fax (610) 868-1446

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, PA, CRNP) complete the following or **attach a written Prescription:**

Name of Medication:_____

Dose: _____

Time Schedule: _____

Purpose of medication:_____

Name of Prescriber (MD, DO, PA, 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,PA, 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) Signature of Parent or Legal Guardian Date