

# AUTHORIZATION FOR MEDICATION TO BE TAKEN DURING SCHOOL

I HEREBY REQUEST AND AUTHORIZE Hillel Academy of Pittsburgh to give my child/ward medication as specified below, according to the *Hillel Academy Medication Policy*. In making this request, I acknowledge that I have been advised that: no physician will be present or available during the administration of medication; a school nurse will not be present or available for that purpose; and medication will be administered by school personnel. **Unless the medication is in an original, labeled container with my child's/ward's name, school personnel will not be allowed to administer the medication.**

## USE ONE FORM PER MEDICATION

Name \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_ Teacher \_\_\_\_\_

Name of Medication \_\_\_\_\_

Reason for Medication \_\_\_\_\_

Form of Medication: \_\_\_\_\_ tablet/capsule \_\_\_\_\_ liquid \_\_\_\_\_ inhaler \_\_\_\_\_ other \_\_\_\_\_

Storage Requirements: \_\_\_\_\_ none \_\_\_\_\_ refrigerate \_\_\_\_\_ other \_\_\_\_\_

Dose of Medication \_\_\_\_\_

Time/s of day to be given \_\_\_\_\_

Side effects: \_\_\_\_\_ none anticipated \_\_\_\_\_ yes – please describe \_\_\_\_\_

Start date \_\_\_\_\_ Stop date \_\_\_\_\_

Prescribing Physician \_\_\_\_\_ Phone \_\_\_\_\_

*If medication is not to be given daily, describe situations in which it should be given:*

\_\_\_\_\_  
\_\_\_\_\_

How often can it be repeated? Every \_\_\_\_\_ minutes Every \_\_\_\_\_ hours

Maximum number of doses per school day \_\_\_\_\_

Parent/Guardian: Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_