ELIZABETH FORWARD School District

401 Rock Run Road, Elizabeth, PA 15037

Health Services Department
Physician's Instructions for Administering Medication During School Hours

(Please Print)

Name of Student _____

Date of Birth _____/_____/_____ Child's Social Security # _____/_____/_____

Address _____ School _____

_____ Grade/Homeroom _____

Diagnosis _____ Date of Order _____/_____/_____

Name of Medication _____

Dosage _____ Route _____ Frequency _____

- If an inhaler, may the student carry it with him/her? _____
- If an epi-pen, may the student carry it with him/her?_____

How long do you expect the medication to be given? _____

Can a reaction be expected? _____ If so, please describe _____

_____

Signature of Physician _____ Date _____

Physician's Name (Please print) _____

Office location _____ Phone number _____

I, _____, fully understand the directions that have been given to the school by the physician and agree to permit school personnel to administer the medication to my son/daughter _____, according to the directions given by the physician listed above.

I hereby release the Elizabeth Forward School District, or any of its employees from any and all liability incidental to providing services as herein requested.

Signature of Parent/Guardian _____ Date _____

Phone Numbers – Home _____ Work _____ Cell _____