PORTAGE AREA SCHOOL DISTRICT
AUTHORIZATION FOR
PRESCRIPTION MEDICATION DURING SCHOOL HOURS

_____ ***must receive the following prescribed medication during school hours, in order to maintain sufficient health to participate in the school program:***

NAME OF MEDICATION _____

PRESCRIBED DOSAGE _____

TIME SCHEDULE _____

LENGTH OF TIME (DAYS/WEEKS) _____

DIAGNOSIS _____

POSSIBLE SIDE EFFECTS _____

I do hereby release, discharge and hold harmless the Portage Area School District, its agents and employees, from any and all liability and claim whatsoever for the administration of the above medication to my child/ward should there develop an allergic or other adverse reaction from the above medication/s.

_____ _____

Signature of Physician / Date ***Signature of Parent/Guardian / Date***

_____

Physician phone number