updated 2/2023

ALLENTOWN SCHOOL DISTRICT HEALTH SERVICES
AUTHORIZATION FOR MEDICATION DURING SCHOOL HOURS

FOR THE PHYSICIAN:

Student Name: _____ must receive medication prescribed by me for the following condition:_____.

This medication must be given during school hours in order to maintain sufficient health and participation in the school program. Medication _____
Prescribed daily dosage _____
Time and dosage to be given in school _____
Duration period _____
Possible side effects _____

Permission is given to self-carry and administer asthma inhaler, epinephrine autoinjector, and/or diabetes medication and monitoring equipment during school hours ☐ Yes ☐ No ☐ Yes, only during field trips
Does the child demonstrate knowledge of how to use asthma inhaler, epinephrine autoinjector, and/or diabetes medication and monitoring equipment ☐ Yes ☐ No

Date_____ Physician Signature: _____

Print Name of Physician _____ Phone Number _____

FOR THE PARENT OR GUARDIAN:

I give permission for the Allentown School District and/or their designee to administer the above medication to my child ***(Student Name)*** _____ as prescribed by the physician.

I agree to deliver medication to school in a labeled prescription bottle. The label must include the name of the medication, the prescribed dosage, the physician's name and the pharmacy.
I agree to deliver a new supply of medication to the school, as needed.
I authorize the Allentown School District to exchange health-related information with the above-named Physician.
I understand that a new medication authorization form must be completed by the parent and physician if the dosage is changed at any time.
Delayed School Openings – medication given on a schedule will NOT be given late at school when there is a delayed opening, but should be given at the scheduled time at home.
Field Trips – medication will not be sent on field trip unless specific arrangements have been made with the school nurse.
Emergency Procedures /Epinephrine – when anaphylactic symptoms are demonstrated, ASD emergency procedures, including the use of Epinephrine auto injectors, will be followed. Please contact your school's nurse with any concerns.
I agree to pick up my child's medication(s) the last day of school.

_____ _____
Date Parent(s) or Guardian(s) Signature

MEDICATION PICK UP.

Date picked up _____ Signature of parent(s) or Guardian(s)_____

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Does the child demonstrate knowledge of how to use asthma inhaler, epinephrine autoinjector, and/or diabetes medication and monitoring equipment ☐ Yes ☐ No

Date_____ Physician Signature_____

Print Name of Physician _____ Phone Number _____

Para el Padre o Guardián:

Por este medio autorizo al Distrito Escolar de Allentown a administrarle el siguiente medicamento a mí Hijo/a ***(Nombre)***_____, como lo recetó el doctor.

Estoy de acuerdo en traer el medicamento en una botella con etiqueta. La botella tendrá el nombre del estudiante, el nombre del medicamento, la dosis prescrita, el nombre del medico, y el nombre de la farmacia.
Estoy de acuerdo que el Padre/Guardián debe estar al tanto de la cantidad de medicamento que se tiene en la escuela, y debe traer el abastecimiento necesario de tal medicamento.
Entiendo que en el momento que se cambiara la dosis prescrita, el padre y el medico han de completar nuevos formularios y el padre debe traer a la escuela el formulario con la nueva información.
Autorizo al Distrito escolar de Allentown comunicarse e intercambiar información con el doctor citado arriba.
Retraso/Apertura Tarde--Los medicamentos que se dan a cierto horario, NO serán dados más tarde en días de retraso al horario escolar. Deberían de ser administrados a la hora indicada en casa.
Paseos Escolares—Los medicamentos NO serán enviados a paseos escolares a menos que se hagan arreglos específicos con la enfermera de la escuela de su hijo/a.
Procedimientos en caso de Emergencias/Epinefrina--Por favor tenga presente que los procedimientos de emergencia de ASD se seguirán en caso de una emergencia. Las inyecciones de epinefrina serán administradas en el caso de que se demostrara síntomas de un ataque anafiláctico. Favor de comunicarse con la enfermera de la escuela de su hijo/a si tiene algunas preguntas o preocupaciones.
Estoy de acuerdo en recoger el medicamento o la medicina de mi hijo/a el último día de clases

Fecha _____ Firma del Padre/Guardián_____

EL MEDICAMENTO O LA MEDICINA FUE RECOGIDA.

Fecha _____ Firma del Padre/Guardián_____