AUTHORIZATION FOR MEDICATION DURING SCHOOL HOURS

This form must be completed whenever any medication must be given to a student during school hours in order that a continuous medication regime is maintained. Medication must be packaged in the properly labeled pharmacy container. Medication must be HAND DELIVERED to the school by the PARENT/GUARDIAN.

To the Physician:

_____ _____ Infinity Charter School

Student Last Name, First Name D.O.B.

Diagnosis: _____

Medication and dosage: _____

Route of administration (oral, injection, etc.): _____

Time schedule: _____

Duration of administration (days, weeks): _____

Possible side effects or contraindications: _____

Other medication student is taking: _____

_____

Date: _____

_____ _____

Physician's Signature Phone Number

_____

Physician's Name (please print)

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To the Parent:

I authorize Infinity Charter School to administer the above medication as prescribed. I do hereby release, discharge and hold harmless the Infinity Charter School, its agents and employees, from any and all liability and claim whatsoever for the administration of the above medication to my child.

_____ _____

Parent/Guardian signature Date

Infinity Charter School 51 Banks Street, Suite 1 Penbrook PA 17103
(717) 238-1880 (phone) (717) 238-1190 (fax)
info@infinityschool.org