Moravian Academy
AUTHORIZATION FOR MEDICATION DURING SCHOOL HOURS

Date: ____________________________

My child, _________________________________, must receive the following prescribed medication during school hours in order to maintain sufficient health to participate in the school program. I will provide the medicine in an appropriately labeled, original pharmacy container.

Name of medication: ____

Prescribed dosage: ____

Time schedule: ____

Physician: ____

Physician telephone number: ____

Pharmacy: ____

Pharmacy telephone number: ____

List side effects of medication: ____
____

Diagnosis <u>and</u> necessity of medication during school hours: _________________
____

Expected duration of medication regime: __________________________________

If the student may carry and be responsible for Epipen or metered dose inhaler, please initial here.

_______ prescriber __________ date
_______ parent __________ date

I do hereby release, discharge and hold harmless, Moravian Academy, its agents and employees, from any and all liability and claims whatsoever in connection with the administration of the above medication to my child.

_________________________________ _________________________________
Signature of Parent or Guardian Signature of Physician

5/08