



**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 or over the counter container.

Medication must be HAND DELIVERED to the school by the GUARDIAN.

FROM the Physician:

Student Last Name, First Name Grade 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)

FROM the Guardian:

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

Guardian Signature Date

The City is Our School
215 N. Front Street; Harrisburg, PA 17102
www.sseschool.org

office@sseschool.org

Office: 717-238-8590

Fax: 717-238-0565