

**Charleroi Area School District**  
**Authorization to Administer Prescribed Medication**

Charleroi Elementary School  
75 Fecsen Drive  
Charleroi, PA 15022  
Phone 724-483-5554  
Fax 724-489-9367

Charleroi Middle/High School  
100 Fecsen Drive  
Charleroi, PA 15022  
Phone 724-483-3600  
Fax 724-489-9128

Name of Student \_\_\_\_\_ Date \_\_\_\_\_ HR \_\_\_\_\_

*Student must receive the following prescribed medication during school hours in order to maintain sufficient health to participate in school programs.*

Name of Medication \_\_\_\_\_

Dosage \_\_\_\_\_ Time(s) \_\_\_\_\_ Frequency \_\_\_\_\_

Expected Duration of Medication Administration \_\_\_\_\_

Possible Side Effects, If Any \_\_\_\_\_

Other Medication that Student is taking outside of School Hours \_\_\_\_\_

Allergies \_\_\_\_\_

Special Instructions \_\_\_\_\_

**For Middle/High School Students---**Student May Carry Inhaler (check appropriate box.)

YES \_\_\_\_\_ NO \_\_\_\_\_

**IF STUDENT NEEDS TO USE INHALER MORE FREQUENTLY THAN PRESCRIBED OR IS CONTINUING TO HAVE DIFFICULTY THEY MUST SEE THE SCHOOL NURSE IMMEDIATELY.**

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

(I, We) do release, discharge and hold harmless the Charleroi Area School District, its agents and employees from any and all claims or liabilities whatsoever arising out of the administration of the above medication to my child. (I, We) do authorize the Charleroi Area School District to disclose protected health information contained on this Authorization in order to comply with the Physician's Orders set forth above, or for the purpose of treatment, payment, or health care operations (45 C.F.R. §164.502(a)(I)(ii) and §164.506).

Intending to be legally bound, (I, We) have executed this release on

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent or Guardian