Holly Area Schools

Physician's Authorization for Medication at School

Valid for school year_____

Form must be renewed with each school year and with any changes to medication

Student's Name: _____ Date of Birth: _____

Parent(s): _____ Phone: _____ Cell: _____

Specify medication type: ☐ Daily ☐ Emergency ☐ As Needed (PRN)

Medication #1 _____ Dosage: _____ Route: _____

Form of medication (circle): Pill/Capsule Liquid Inhaler Nebulizer Injection Topical Drops

Time to be given at school: _____ Potential side effects: _____

If PRN, frequency: _____ ***If PRN or Emergency use** (please list symptoms present to indicate administration of medication): _____

Specify medication type: ☐ Daily ☐ Emergency ☐ As Needed (PRN)

Medication #2 _____ Dosage: _____ Route: _____

Form of medication (circle): Pill/Capsule Liquid Inhaler Nebulizer Injection Topical Drops

Time to be given at school: _____ Potential side effects: _____

If PRN, frequency: _____ ***If PRN or Emergency use** (please list symptoms present to indicate administration of medication): _____

Specify medication type: ☐ Daily ☐ Emergency ☐ As Needed (PRN)

Medication #3 _____ Dosage: _____ Route: _____

Form of medication (circle): Pill/Capsule Liquid Inhaler Nebulizer Injection Topical Drops

Time to be given at school: _____ Potential side effects: _____

If PRN, frequency: _____ ***If PRN or Emergency use** (please list symptoms present to indicate administration of medication): _____

_____ _____ _____

Physician's Name (Print) Physician's Signature Date

Holly Area Schools is not a medical facility. To the extent practicable and safe for the student, medication should be administered during non-school hours.

PARENT'S PERMISSION
MEDICATION MUST BE IN ORIGINAL CONTAINER

I hereby request that my child receive the above medication during school hours per the physician's order and the Holly Area Schools (HAS) medication policy. I certify that I have legal authority to consent to medical care/treatment for the student names above, including administration of medications at school. I will not hold the HAS Board of Education, its personnel or employee, responsible for complications related to the medication administered pursuant to this form. Permission to administer medication expires at the end of the school year. I authorize staff to contact the authorizing physician for clarification of these orders if necessary.

_____ _____

Parent Signature Date

5/2024 **Office use:** Skyward Alert: _____ Date: _____ Initials: _____