GINNY L HUNT, Ed.D.
Superintendent

DEBRA A. MAURIZIO, M.Ed.
Director of Curriculum and Federal Programs

HAMSINI RAJGOPAL, M.B.A
Business Administrator

Clairton City School District

School Health Services
501 Waddell Avenue
Clairton, PA 15025
(412) 233-9200 ext. 1124
Fax: (412) 233-4590

Permission to Administer Single Medication

Student Name: _____ DOB: _____ Grade/HR: _____

To Be Completed By Health Care Provider

Diagnosis_____

Medication _____Dose _____ Route _____ Time(s) _____

All medication should be given as close to the prescribed time as possible, however may be given up to one hour before and no later than one hour after the prescribed time. Please advise the school if there is a time-specific concern regarding administration of the medication.

If the morning dose is not given at home, the school nurse may administer morning dose of _____ after verbal or written notification from parent. Please advise parent to send in additional medication.

Name and Title of Licensed Prescriber (Print) _____

Prescriber's Signature _____Date _____Phone_____

To Be Completed By Parent

I give permission for the above medication to be administered to my child as ordered by my health care provider. I will furnish the medication in the original pharmacy container, properly labelled with directions and dosage, or original over-the-counter medication container/packaging with my child's name on it.

Parent/Guardian Signature _____ Date _____