Hazleton Area School District
Parent Approval for Medication
to be given by school personnel.

Name of Student:_____ School_____

Grade and Homeroom:_____

Address:_____

Physicians Name:_____

Dosage:_____

Time to be given:_____

Length of time medication is expected to be taken:_____

Additional Comments: _____

_____

_____

Pertinent side effects of medication that school personnel should be aware of:_____

_____

_____
Parent's Signature

_____ _____
Telephone Number Date

Please Note: No medication will be given to any student unless it is in a properly identified container preferably in a pharmacy container. This container must include students name, identification of the medication, directions for administration and physician's name.