DELAWARE AREA CAREER CENTER

Prescription Form

Student name	
Student Address	Grade/program

PARENT/GUARDIAN AUTHORIZATION

I authorize school personnel to administer the medication as instructed by the physician. I understand that a trained staff member administering the medication might not be a health professional. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability foreseeable or unforeseeable for the damages or injury resulting directly or indirectly from this authorization. I agree that school officials are authorized to contact the physician on matters relating to the medication. I understand that the medication must be in the original container and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration and the date of drug expiration.

Parent/Guardian signature	Date	#1 contact phone	#2 contact phone

PHYSICIAN AUTHORIZATION

Name of medication:	Circumstances for use:
Dosage:	Route:
Time/ Interval:	Start and end time for medication:
Special instructions:	
Possible severe adverse reactions to observe (to be reported to physician):	
Possible severe adverse reactions that may occur to another student for whom the medication is not prescribed, should he/she receive a dose of medication:	
Procedures for the school employees if the medication does not produce the expected relief:	
Physician's signature:	Date:
Physician's name:	Physician's emergency telephone number: ( )