BEHAVIORAL HEALTH ASSOCIATES
"Where education meets understanding."
200 Beaver Run Road | Lehighton, PA 18235
Phone: (610) 379-1266 | Web: bhaedu.com

Authorization For Medication During School Hours

To be completed by the prescriber:

_____ _____
(Student Name) (Date)

Must receive the following prescribed medication during school hours to maintain sufficient health to participate in the school programs.

Medication(s): _____

Prescribed Dosage: _____

Time to be given: _____Diagnosis: _____

Side Effects: _____

Prescriber Name: _____Prescriber Signature: _____

Address:_____Phone# _____

Today's Date: _____

To be completed by the parent or guardian:

I do hereby release, discharge, and hold harmless Behavioral Health Associates, its agents and employees, from any and all liability and claim whatsoever for the administration of the above medication to my child, should there develop an allergic reaction or other reaction from the medication. I understand that I am responsible for any mishandling of medication while transported by my child.

Signature of Parent/Guardian: _____

Date: _____