

**Dr. Erica L. Kolat**

**Superintendent**

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District Administration Offices 724-948-3731 Fax—724-948-3769

Special Services —-724-663-5364 Fax—724-663-3696

High School—-724-948-3328

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Fax—724-222-2630

Claysville—724-663-7772

Fax—724-663-4298

Middle School—724-948-3323

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**McGuffey School District**

90 McGuffey Drive

Claysville, Pennsylvania 15323

 **Amy L. Todd**

 **Business Administrator**

 **todda@mcguffey.k12.pa.us**

AUTHORIZATION FOR MEDICATION DURING SCHOOL HOURS

To: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Building Administrator)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ must receive the following prescribed

and/or non-prescribed medication, including vitamin and herbal supplements, during school

hours in order to maintain sufficient health to participate in the school program.

 Name of medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name of vitamin/herb supplement: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Prescribed dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Time schedule: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Length of time: \_\_\_\_\_ days \_\_\_\_\_ months \_\_\_\_\_ end of school year

 Possible side effects: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of Physician Date

I do hereby release, discharge and hold harmless the McGuffey School District, its agents

and employees from any and all liability and claim whatsoever for the administration of the

above medication and / or vitamin and herbal supplements to my child should the child

develop a reaction from the medication.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of Parent/Guardian Date