Prescription Medication Form

Print Form

South Williamsport Area School District
515 West Central Ave.
South Williamsport, PA
17702

Phone: 570-327-1581
Fax: 570-326-0641
www.swasd.org

Student Information

Student: _____

Age: _____

Grade: _____

School: _____

Medication Information

_____ **Medication Name**

_____ **Time to be Given**

_____ **Strength**

_____ **Route of Administration**

_____ **Dosage**

_____ **Purpose of Medication**

_____ **Duration of Order**

Side effects that may impact health or school activities / performance

General comments for school health staff or teachers

Authorizations	
Physician's Signature & Date	**Physician's Name (PRINT)**
As parents / guardians of the student listed above, we release the South Williamsport Area School District and all its employees from any and all liability for damages our student may suffer as a result of this request for administration of this prescribed medication.	
Parent / Guardian Signature & Date	**Parent / Guardian Name (PRINT)**
For your convienence, this form can be faxed to: **Central Elementary** (570) 320 - 4492, **Rommelt Elementary** (570) 567-0807, or **Jr. / Sr. High School** (570) 326 - 2687	