

CARMICHAELS JR./SR. HIGH SCHOOL

300 WEST GREENE STREET
CARMICHAELS, PA 15320-9759



TEL. 724-966-5045
WWW.CARMAREA.ORG

JOHN MENHART
Jr./Sr. High Principal
Ext 3104 Fax 724-966-5556
Email - jmenhar@carmarea.org

MARY ANN TAYLOR
Asst. to Jr./Sr. High Principal
Ext 2254 Fax 724-966-5839
Email - mtaylor@carmarea.org

Authorization for Medication During School Hours

(Student's Name) _____ must receive the following prescribed medication during school hours in order to maintain sufficient health to participate in the school program:

Name of Medication	_____
Prescribed Dosage	_____
Time of Administration	_____
Duration of Treatment	_____
Reason for Medication	_____
Possible Side Effects	_____
Special Instructions	_____

Physician's Signature *Date*

Physician's Name (Typed/Printed)

Address

Phone Number

THE FOLLOWING IS TO BE COMPLETED BY THE PARENT/GUARDIAN:

I do hereby release, discharge, and hold harmless the Carmichaels Area School District, its agents, and employees from any and all liability and claim whatsoever for the administration of the above medication to my child.

Parent/Guardian Signature *Date*

Address

Phone Number