HERITAGE VALLEY PEDIATRICS
250 COLLEGE AVE
BEAVER, PA 15009

Medication Administration Authorization

Date:

School Name:

Patient Name:

The parent/guardian of _____has requested that the medications listed below be administered during the school day in the event they can not be given before or after school hours.

Name of Medication(s):

Dosage: **Time:**

How to be administered (oral or injection):

Duration of Medication Administration:

Possible side effects or contraindications:

Curtailment of specific school activity:

Other medications currently taking:

Is student capable of self administration?

HVPeds Physician Signature_____ Date: _____