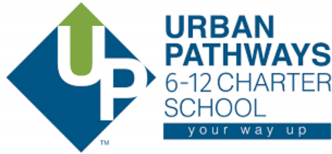

AUTHORIZATION FOR MEDICATION DURING SCHOOL HOURS

____ must receive the following prescribed
(Full Name of Pupil)
medication during school hours in order to maintain sufficient health to participate in the school program:

Name of medication____

Prescribed dosage____

Time schedule____

Length of time__________Days__________Months___________Indefinitely____________

Diagnosis____

Reason for administration____

Possible side effects____

| do hereby release, discharge the hold harmless the URBAN PATHWAYS 6-12 CHARTER SCHOOL, its agents and employees, from any and all liability and claim what whatsoever for me of the above medication to my child should there develop a reaction from the medication.

_________________________________ _________________________________
(Signature of Physician) (Date) (Signature of Parent/Guardian) (Date)