EAST PENN SCHOOL DISTRICT

Administrative Offices
800 Pine Street
Emmaus, PA 18049
610-966-8300

Authorization For Treatment During School Hours

This treatment authorization form must be completed annually in order for staff to administer required treatments.

HEALTH CARE PROVIDER AUTHORIZATION		
Name of Student:	Date of Birth:	Grade/Room:
Primary Diagnosis:		
Medical Treatment to be Administered:		
Start Date:	Stop Date:	
Time of Administration:	If PRN, frequency:	
Health Care Provider's Name/Title: (print)		Health Care Provider's Signature:
Date:	Telephone:	Fax:

PARENT/GUARDIAN AUTHORIZATION	
We/I request designated staff to administer the medical treatment as prescribed by the health care provider above. We/I hereby release, discharge and hold harmless the East Penn School District, its agents and employees from any and all liability and claim whatsoever on behalf of ourselves and our child for the treatment described above.	
Date:	Parent/Guardian Signature:
Date:	Parent/Guardian Signature:

Note: Parent/Guardian is responsible for supplying, maintaining, and delivering equipment/supplies necessary for treatment to school. Equipment cannot be a potential hazard to others in the environment.