

AUTHORIZATION FOR PRESCRIBED MEDICATION OR TREATMENT

To the Parent:

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO USE PRESCRIBED MEDICATIONS OR TO RECEIVE TREATMENT IN SCHOOL. ALL SPACES MUST BE COMPLETED.

_____ Name of Student	_____ Address
_____ School	_____ Grade

- A. I am requesting permission for my child named above to: (Check all that apply)
- \_\_\_\_\_ use or receive prescribed medication
  - \_\_\_\_\_ receive prescribed treatment
  - \_\_\_\_\_ self-administer prescribed medication(s) in my presence or that of an authorized staff member
- in accordance with the Doctor's prescription.
- B. I will assume responsibility for safe delivery of the medication to school.
- C. I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment.
- D. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

_____ Signature of Parent	_____ Date
_____ Home Telephone	_____ Work Telephone

PHYSICIAN STATEMENT

To the Physician:

The School District requires that all of the following information be provided before it will administer medication or treatment to the student.

\_\_\_\_\_  
Name of Student    Address

\_\_\_\_\_  
School/Class/Grade

I have prescribed the following medication \_\_\_\_\_  
\_\_\_\_\_

Beginning Date \_\_\_\_\_ Ending Date \_\_\_\_\_

Dosage, instructions, or precautions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Report the following side effects to my office immediately \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physician's Signature \_\_\_\_\_ Telephone \_\_\_\_\_

Printed/Typed Name \_\_\_\_\_ Date \_\_\_\_\_

**AUTHORIZATION FOR STAFF**

The following staff members are authorized to administer the above-prescribed medication(s)/treatment(s):

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Principal