PARENT REQUEST AND AUTHORIZATION TO ADMINISTER A PRESCRIBED MEDICATION/DRUG 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	School	Grade

Address	Birthdate

A. Authorization is hereby given for the student named above to: (Check all that apply)

- ☐ Receive the prescribed medication indicated from the designated school personnel.
- ☐ Self-administer such medication in the presence of an authorized staff member.

B. I will assume responsibility for safe delivery of the medication/drug to school. (The medication/drug must be received by the District (i.e. the person authorized to administer the drug to the student) in the container in which it was dispensed by the physician or a licensed pharmacist.

C. I will notify the school immediately if there is any change in the use of the medication/drug for the prescribed treatment. I will submit to the District a revised physician's statement, signed by the physician, if any of the information contained in the statement changes.

D. I release and agree to hold the Board of Education, its officials, and it employees harmless from any and all liability foreseeable for the damages or injury resulting directly or indirectly from this authorization.

Signature of Parent	Date

Primary Telephone Number	Additional Telephone Number

The reverse side of this page must be completed and signed by a physician in order for prescribed medical/treatment to be given in school.

AUTHORIZATION

Only employees or contractors of the Board who are licensed health professionals or who have completed a drug administration training program conducted by a licensed health professional and are designated by the Board may administer prescription and nonprescription drugs to students in school.

PHYSICIAN'S 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 School Grade

____ ______________

Student's Address Birthdate

I am a licensed health professional authorized to prescribe drugs, and I have prescribed the following medication to the above named student (specify the name of the drug – only one drug per form) :

____

- Reason for Medication: ______________________________
- Date the administration of the drug is to begin: ______________________
- Date the administration of the drug is to cease: ______________________

Specify the dosage of the drug to be administered, and the times or intervals at which each dosage of the drug is to be administered: ______________________________

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Specify any special instructions for administration of the drug, including sterile conditions and storage:

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____

Report the following side effects (i.e., severe adverse reactions) to my office immediately:

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____ ________________

Physician's Signature Physician's Telephone

____ ________________

Printed/Typed Name Date

____

Physician's Address

Please use one form for each prescribed medication/treatment. This form is two-sided.

1/14/13
3/18/13