PRESCRIBED MEDICATION AUTHORIZATION

To the Parent or Adult Student:

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT WHO POSSESS OR USES MEDICATIONS IN SCHOOL EACH OF WHICH MUST BE PRESCRIBED; ALL SPACES MUST BE COMPLETED.

_____ _____
Name of Student Telephone

_____ _____
Address Date of Birth

_____ _____
School Room

1. I am requesting permission for the student named above to possess and use medication according to the doctor's verification on this card.
2. I will assume responsibility for safe delivery of the medication to school, either by myself or by the student.
3. I will notify the school immediately if there is any change in the use of the medication.
4. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

_____ _____
Signature of Parent or Adult Student Date

_____ _____
Home Telephone Work Telephone

PHYSICIAN STATEMENT

To the Physician:

The Board of Education urges you to schedule the taking of medications by students at times outside of school hours. When that is not possible, the possession and use of medications will be permitted, insofar as feasible, during school hours. Medication in pill form is preferable to liquids for use in school.

I verify that this medication must be taken by _____
Student

_____ _____ _____
Medication Dosage Route

Medication is to be taken at the following times _____

Instructions or precautions (including possible side effects): _____

_____

Beginning Date _____ Expiration Date _____

Physician _____ Date _____

Printed/Typed Name _____ Telephone _____