# 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

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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

____________________________________________ ______________________________
SchoolClass/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-nonprescribed medication(s)/treatment(s):

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________
Principal

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