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	Date of Birth
_____	_____
Address	School
_____	_____
City, State, Zip	Grade

A. I am requesting permission for my child named above to: (Check all that apply)

_____ use or receive prescribed medication

(The medication must be in the original pharmacy labeled package with the following information in a legible format: student's name, practitioner's name, date, pharmacy name and telephone, name of medication, prescribed dosage and frequency, and special handling and storage instructions.)

_____ 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 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 named on the reverse side.

I have prescribed the following medication _____

_____

_____

Beginning Date _____ Ending Date _____

Dosage, instructions, or precautions (including possible side effects): _____

_____

_____

_____

I have prescribed the following treatment _____

_____

_____

_____

_____

_____

Beginning Date _____ Ending Date _____

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

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