

**GREATER JASPER CONSOLIDATED SCHOOLS
AUTHORIZATION FOR PRESCRIBED MEDICATION OR TREATMENT**

To the Parent/Guardian

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/Teacher

PHYSICIAN'S AUTHORIZATION FOR MEDICATION

This student requires the administration of a prescription medication during school hours. This medication should be administered as follows:

Medication Name/Treatment Dosage Hour/hours given Stop date

1.

2.

Date

Physician's Signature

Has been instructed on self-administering inhaler and may carry on person. _____
Physician Initial & date

PARENT AUTHORIZATION FOR PRESCRIBED MEDICATION OR TREATMENT

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

_____ receive prescribed medication

_____ receive prescribed treatment

_____ self-administer prescribed Inhaler (in presence of authorized staff member/or to inform authorized staff member immediately after use.)

in accordance with Physician's prescription.

B. I will assume responsibility for safe delivery of medication to school. I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment.

C. I authorize greater Jasper Consolidated Schools to release/exchange/share information between themselves.

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/Guardian

Date

Home Telephone

Work Phone

Cell Phone