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 for damages or injury resulting directly or indirectly from this authorization.

_____   _____
Signature of Parent   Date

_____   _____
Home Telephone   Work Telephone

    Medication: _____

    Dosage: _____

    Medication: _____

    Dosage: _____

PHYSICIAN STATEMENT

To the Physician:

The Corporation 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