JACKSON MILTON LOCAL SCHOOLS
AUTHORIZATION FOR PRESCRIBED MEDICATION OR TREATMENT

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

I am a licensed health professional authorized to prescribe drugs, and I have prescribed the following medication:

Medication Name: ________________ Dosage: ________________

Beginning Date: ________________ Ending Date: ________________

Instructions: ________________________________

Precautions: ________________________________

Report the following side effects to my office immediately: ________________

____

Prescriber's Signature: ________________ Telephone: ________________

Printed/Typed Name: ________________ Date: ________________

Parent/Guardian must complete the information below:

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

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 or Cell Telephone