AUTHORIZATION FOR PRESCRIBED MEDICATION/DRUG 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: _____ DOB: _____

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
_____ for student with diabetes only: self-administer diabetes care in accordance with Policy 5336

in accordance with the doctor's prescription.

B. I will assume responsibility for safe delivery of the medication/drug to school, except for diabetes medication student is permitted to possess pursuant to Policy 5336.

C. I will notify the school immediately if there is any change in the use of the medication/drug or the prescribed treatment, or if I wish to revoke this authorization.

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 from this authorization.

Signature of Parent: _____ Date: _____
Home Telephone: _____ Work Phone: _____

LICENSED PRESCRIBER'S STATEMENT

To the Prescriber:

The School District requires that all of the following information be provided before it will administer medication or treatment to the student named on this form.

I have prescribed the following medication: _____
Dosage, instructions, or precautions (including possible side effects): _____
_____

Beginning Date: _____ Ending Date: _____

I have prescribed the following treatment: _____
_____
Beginning Date: _____ Ending Date: _____

For student with diabetes only:

_____ I authorize the student to attend to his/her diabetes care and management, in accordance with my order during regular school hours and school sponsored activities. I have determined that the student is capable of performing diabetes care tasks.

_____ I do not authorize the student to attend to his/her diabetes care and management during regular school hours and school sponsored activities.

Prescriber's Signature: _____ Phone: _____ Fax: _____
Printed/Typed Name: _____ Date: _____