ELIDA LOCAL SCHOOLS 5330 F1C

AUTHORIZATION FOR DIABETIC MEDICATION

FOR DIABETICS ONLY

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 Student Date of Birth

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 posses 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 Telephone

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 ______________________________

____

____

Beginning Date ______________________ Ending Date

____

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

____

____

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______________________Telephone

____

Printed/Typed Name ________________________ Date

____

AUTHORIZATION FOR STAFF

The following staff members are authorized to administer the above-prescribed medication(s)/treatment(s):

____

____

____
Principal

11/05
10/06
7/07
10/13/14
4/29/15
10/3/17
7/25/19

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