Community School Corporation of Southern Hancock

PARENT REQUEST AND AUTHORIZATION TO ADMINISTER

PRESCRIBED MEDICATION/DRUG 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.

_____ _____

Student Name Grade/School

_____ _____ Medication

Dose Route Time

_____ _____

Reason for taking How long medication should be taken or (school year)

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 authorized prescription.

B. I will assume responsibility for safe delivery of the medication/drug to school per school policy. (The medication/drug must be received by the District (i.e., the person authorized to administer the drug to the student) in the container in which it was dispensed by the prescriber or a licensed pharmacist.)

C. I will notify the school immediately if there is any change in the use of the medication/drug or the prescribed treatment. (You must submit to the District a revised licensed prescriber's statement, signed by the prescriber, if any of the information contained in the statement changes.)

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/Guardian Date

_____ _____ Home

Telephone Work Telephone

*Controlled Substance Only: _____ _____ _____

Amount in Bottle at drop off Initial Staff initial

**Medication form good only for current school year. All medications must be picked up before school year ends

12/2016