AUTHORIZATION FOR MEDICATION OR TREATMENT

Dear Parent:

The following information is necessary for the dispensing to any student prescribed or non-prescribed medications or to receive treatment in school. All spaces must be completed.

_____ _____
Name of Student Telephone No.

_____ _____
Address Birthdate

_____ _____
School Teacher

1. I am requesting permission for my child named above to:
(Check one or both.)

_____ Use or Receive Medication

Name of Medication: _____

Dosage: _____ Time Dose Given: _____

_____ Receive Treatment: Time: _____

_____
(Describe treatment)

in accordance with the Doctor's prescription.

2. I will assume responsibility for safe delivery of the medication to school, either by me or my child.

3. I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment.

4. 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/Guardian Date

_____ _____
Home Telephone Work Telephone