

**NORTHEAST DUBOIS SCHOOL CORPORATION
AUTHORIZATION FOR PRESCRIBED MEDICATION OR TREATMENT**

To the Parent/Guardian

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

Grade / Teacher

PHYSICIAN'S AUTHORIZATION FOR MEDICATION (To be filled out by PHYSICIAN)

This student requires the administration of a prescription medication during school hours. This medication should be administered as follows:

<u>Medication Name/Treatment</u>	<u>Dosage</u>	<u>Hour/hours given</u>	<u>Stop Date</u>
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1.

2.

3.

Has been instructed on self-administering inhaler and/or epinephrine pen (if applicable). Yes / No

May carry epinephrine pen and/or inhaler on person (if applicable). Yes / No

Date

Physician's Signature

PARENT AUTHORIZATION FOR PRESCRIBED MEDICATION OR TREATMENT (For PARENT)

A. I am requesting permission for my child named above to: (Check all that apply)

_____ receive prescribed medication _____ receive prescribed treatment

_____ self-administer prescribed inhaler and/or EpiPen (in presence of authorized staff members/or to inform authorized staff member immediately after use by student (if applicable) in accordance with Physician's prescription.

B. I will assume responsibility for safe delivery of 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 for damages or injury resulting directly or indirectly from this authorization.

Signature of Parent/Guardian

Date

Home Telephone

Work Phone

Cell Phone