AUTHORIZATION FOR MEDICATION OR TREATMENT FORM

To the Parent/Guardian:

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO POSSESS OR USE PRESCRIBED OR NON-PRESCRIBED MEDICATIONS OR TO RECEIVE TREATMENT IN SCHOOL. ALL APPROPRIATE SPACES MUST BE COMPLETED.

Student Name: _____

Date of Birth: _____ Grade: _____

Circle one: ☐ Lincoln ☐ Jane Ball ☐ Red Cedar ☐ Middle School ☐ High School

Prescribed Medications: Must be in the original pharmacy labeled container.

Prescribed medications must be accompanied by the *Physician Authorization Form*.

I am requesting permission for my child (named above) to:

_☐_ Use or receive medication/treatment

_☐_ I have the necessary authorization from my physician.

Non-Prescribed Medications: Must be in the original labeled container.

I am requesting permission for my child (named above) to:

_☐_ Use or receive medication

Type of Illness or Disease: _____

Name of Non-Prescribed Medication: _____

Dosage: _____

How Often: _____

I will assume responsibility for safe delivery of the medication to school. I will notify the school immediately if there is any change in the use of the medications or prescribed treatment. I release and agree to hold the Board of School Trustees, its officials, and its employees harmless from any and all liability for damages or injury directly or indirectly from this authorization. I authorize approved school personnel to administer medication. I have read and understand the Medication Policy 5330 and fully understand the requirement that my child may never possess, self-administer, or provide medications (prescribed or non-prescribed) to another person (except for the reasons detailed in the policy) and that the school system will treat violations seriously.

Parent/Guardian Signature: _____

Date of Signature: _____

Emergency Phone Number: _____

Reminder: All medication authorization forms must be completed each school year.