GREATER JASPER CONSOLIDATED SCHOOLS
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 Address

_____ _____
School Grade/Teacher

PHYSICIAN'S AUTHORIZATION FOR MEDICATION
This student requires the administration of a prescription medication during school hours. This medication should be administered as follows:

Medication Name/Treatment	Dosage	Hour/hours given	Stop date
1.			
2.			

_____ _____
Date Physician's Signature

Has been instructed on self-administering inhaler and may carry on person._____
Physician Initial & date

PARENT AUTHORIZATION FOR PRESCRIBED MEDICATION OR TREATMENT

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 (in presence of authorized staff member/or to inform authorized staff member immediately after use.)

in accordance with the 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