

AUTHORIZATION FOR PRESCRIBED  
MEDICATION/DRUG OR TREATMENT

To the Parent:

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

\_\_\_\_\_  
Date of Birth

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

\_\_\_\_\_ for student with diabetes only: self-administer diabetes care in accordance with Policy 5336

in accordance with the Doctor's prescription.

B. I will provide the prescribed medication in its original bottle with dosage and directions on the bottle.

C. I will assume responsibility for safe delivery of the medication/drug to school, except for diabetes medication student is permitted to possess pursuant to Policy 5336.

D. I will notify the school immediately if there is any change in the use of the medication/drug or the prescribed treatment, or if I wish to revoke this authorization.

E. 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 from this authorization.

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Home Telephone

\_\_\_\_\_  
Work Telephone

LICENSED PRESCRIBER'S STATEMENT

To the Prescriber:

The School District requires that all of the following information be provided before it will administer medication or treatment to the student named on this form.

I have prescribed the following medication \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Beginning Date \_\_\_\_\_ Ending Date \_\_\_\_\_

Dosage, instructions, or precautions (including possible side effects): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I have prescribed the following treatment \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Beginning Date \_\_\_\_\_ Ending Date \_\_\_\_\_

**For student with diabetes only:**

\_\_\_\_\_ I authorize the student to attend to his/her diabetes care and management, in accordance with my order, during regular school hours and school sponsored activities. I have determined that the student is capable of performing diabetes care tasks.

\_\_\_\_\_ I do not authorize the student to attend to his/her diabetes care and management during regular school hours and school sponsored activities.

Prescriber's Signature \_\_\_\_\_ Telephone \_\_\_\_\_

Printed/Typed Name \_\_\_\_\_ Date \_\_\_\_\_

**AUTHORIZATION FOR STAFF**

The following staff members are authorized to administer the above-prescribed medication(s)/treatment(s):

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\_\_\_\_\_  
Principal

10/12/16

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