Authorization for Prescribed Medication 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.

Student name:_____

Address:_____

School:_____ Class/grade:_____

A. I am requesting permission for my child named to: (check all that apply)
   - ☐ Use or receive prescribed medication(s)
   - ☐ Receive prescribed treatment(s)
   - ☐ Self-administer prescribed medication(s) in my presence or that of an authorized staff member in accordance with the doctor's prescription

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

Parent signature:_____ Date:_____

Home phone:_____ Work phone:_____

Authorization for Prescribed Medication or Treatment

To the physician:

The school district requires that all of the following information be provided before it will administer medication or treatment to the student.

Student name:_____

Address:_____

School:_____ Class/grade:_____

I have prescribed the following medication:_____

_____

Administration start date:_____ End : _____

Dosage, instructions, or precautions:_____

_____

Times required:_____

Report the following side effects to my office immediately:_____

_____

Physician signature:_____ Date:_____

Printed/typed name:_____ Phone:_____

Physician address:_____

Authorization for Staff

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

_____

Principal:_____