AUTHORIZATION FOR MEDICATION AND/OR TREATMENT

To the Parent/Guardian:

The following information is necessary for any student to use prescribed or over-the-counter medications and to receive treatment in school. **All spaces must be completed.**

_____ _____
Name of Student Address

_____ _____
School Grade

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

_____ use or receive prescribed or over-the-counter 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 assume responsibility for safe delivery of the medication/drug to the school, except for diabetes medication student is permitted to possess pursuant to Policy 5336.

C. 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.

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 from this authorization.

_____ _____
Signature of Parent Date

_____ _____
Home Phone Work Phone

Over for additional physician instruction

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 Name: _____ Date: _____

AUTHORIZATION FOR STAFF

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

_____

_____

_____
Principal