SPRINGPORT PUBLIC SCHOOL
MEDICATION AUTHORIZATION FOR PRESCRIBED MEDICATION OR TREATMENT

PARENT PERMISSION

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO USE PRESCRIBED MEDICATIONS IN SCHOOL. ALL SPACES MUST BE COMPLETED.

Student(s) Name _____ DOB _____ Gender (M) (F)

Address _____

School: (ES) (MS) (HS) Teacher/Grade _____

I am requesting permission for my child named above to use or receive prescribed medication in accordance with the Doctor's prescription (see below).

A. I will assume responsibility for safe delivery of the medication to school.

B. I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment

C. 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.

_____ _____ _____
(Parent/Guardian Signature) **(Contact #)** **(Date)**

PHYSICIAN'S STATEMENT

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

I have prescribed the following medication _____

_____

Beginning Date _____ **Ending Date** _____

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

_____

Beginning Date _____ **Ending Date** _____

I have prescribed the following treatment _____

_____

Beginning Date _____ **Ending Date** _____

Physicians Signature _____ Telephone _____

Printed/typed Name_____ Date _____