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	Date of Birth	Grade	School
Address	City, State, Zip		

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

_____ use or receive prescribed medication (The medication must be in the original pharmacy labeled package with the following information in a legible format: student's name, practitioner's name, date, pharmacy name, telephone, name of medication, prescribed dosage, frequency, special handling and storage instructions.)

_____ receive prescribed treatment

_____ Self-administer prescribed medication(s) in my presence or that of an authorize staff member or as noted below. Student has been instructed in the proper way to use his/her inhaled asthma medication or emergency Epipen/allergy medication and should be allowed to carry and use this medication as needed.

A. I will assume responsibility for safe delivery of the medication to school.
B. I will notify the school immediately, in writing 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. School principal/designee may contact child's physician as needed.

Signature of Parent	Date	Home Telephone	Work Telephone

PHYSICIAN: **The School District requires that all of the following information be provided before it will administer medication or treatment to this student.**

Beginning Date _____ **Ending Date**_____

Name and dose of medication	Form: (tablet, capsule, pill)	Number to be taken	Approximate time of day	Term Short/Long

Name of medication, reason for giving and side effects _____

Please indicate if the medication above is PRN (whenever needed) and conditions under which PRN medication should be given _____

_____

If applicable, is the child authorized to carry and self-administer this medication: _____ Yes _____ No

Physician's Signature _____ Printed Name _____

Hospital/Clinic/Office _____ Phone _____ Date _____

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

_____

_____

School Nurse Signature