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.

______________________________	______________________________
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 medication

_____ receive prescribed treatment

_____ 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 for damages or injury resulting directly or indirectly from this authorization.

______________________________	______________________________
Signature of Parent	Date
______________________________	______________________________
Home Telephone	Work Telephone

PHYSICIAN STATEMENT

To the Physician:

The Corporation requires that all of the following information be provided before it will administer medication or treatment to the student named on the reverse side.

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 ______________

Physician'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):

secretary, guidance counselor, school nurse, classroom teacher, assistant principal, principal

Austin Olsher
Principal