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. Before any prescribed medication or treatment may be administered to any student during school hours, the Board shall require the written prescription from the child's physician accompanied by the written authorization of the parent. Both must also authorize any self-medication by the student. (Board Policy 5330)

_____ _____
Signature of Parent **Date**

_____ _____
Home/Cell Number **Work Number**

PHYSICIAN STATEMENT

To the Physician:

Per our School Board Policy 5330, "The Board of Education shall not be responsible for the diagnosis and treatment of student illness. The administration of prescribed medication and/or medically-prescribed treatments to a student during school hours will be permitted only when failure to do so would jeopardize the health of the student, the student would not be able to attend school if the medication or treatment were not made available during school hours, or the child is disabled and requires medication to benefit from his/her educational program."

Name of Student _____ Address _____

School _____ Grade _____

I have prescribed the following medication _____

_____

_____

Beginning Date _____ Ending Date _____

Dosage, instructions, or precautions: _____

_____

_____

_____

Report the following side effects to my office immediately _____

_____

_____

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):

_____

_____

_____
Administrator