AUTHORIZATION FOR PRESCRIBED MEDICATION OR TREATMENT

To the Parent:

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

_____	_____
Name of Student	Address
_____	_____
School	Class/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

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. Our Physician has instructed that this medication should be administered in the above designated dosage.

E. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability foreseeable or unforeseeable 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 School District requires that all of the following information be provided before it will administer medication or treatment to the student.

_____ _____
Name of Student Address

_____ _____
SchoolClass/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):

_____

_____

_____
Principal

MEDICAL INFORMATION

Student Name: _____ Birthdate: month _____/ day _____/ year _____
Street Address: _____ Telephone: (___) _____ - _____
City/Zip _____ _____

INSURANCE INFORMATION

Type of Insurance: Group ____ Individual _____ Policy No. _____
Name and Address of Insurance Co.
_____
_____
_____

Name of Employer/Group: _____
Name of Subscriber _____
Relationship to Student: _____

MEDICAL CARE INFORMATION

Student's Doctor: _____ Telephone (___) _____ - _____
Doctor's Address: _____
_____

Student's Dentist: _____ Telephone (___) _____ - _____
Dentist's Address: _____
_____

REQUEST FOR ADMINISTRATION OF MEDICATION

List current **prescribed** medications along with a complete Physician Statement for each medication to be taken.

MEDICATION	PHYSICIAN STATEMENT Check & attach statement.	DOSAGE	TAKEN HOW OFTEN
_____	☐	_____	_____
_____	☐	_____	_____
_____	☐	_____	_____

Check the following **non-prescribed** medication that may be given

☐ Ibuprofen	☐ Allergy Sinus Tablets	☐ Pepto-Bismal
☐ Tylenol	☐ Benadryl	☐ Tums
☐ Dramamine	☐ Imodium A-D	☐ Midol

List any other non-prescription medication you may wish your child to take:
_____

List any allergies or other conditions of which the leadership should be aware:
_____
_____

Is there any history of excessive bleeding? Yes☐ No☐

Date of last Tetanus shot ____/____/____

Signature of Parent/Guardian: _____ Date: month _____/ day _____/ year ____

1/05