AUTHORIZATION FOR MEDICATION OR TREATMENT

To the Parent or Adult Student:

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

_____	_____
Name of Student	Telephone
_____	_____
Address	Date of Birth
_____	_____
School	Room

1. I am requesting permission for my child named above to: (check one or both)
   _____ use or receive medication _____ receive treatment
   in accordance with the Doctor's prescription.
2. I will assume responsibility for safe delivery of the medication to school, either by me or by my child.
3. I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment.
4. 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 or Adult Student	Date
_____	_____
Home Telephone	Work Telephone

PHYSICIAN STATEMENT

To the Physician:

The Board of Education urges you to schedule, to the extent possible, medication or treatment of a student outside of school hours. When that is not possible, medications and/or treatment will be permitted, insofar as feasible, during school hours. Medication in pill form is preferable to liquids for use in school.

I have prescribed the following to be administered to _____
Student

_____ _____
Medication Dosage

Medication is to be taken at the following times: _____

Instructions or precautions (including possible side effects):_____

_____

_____

_____

Treatment –

Beginning Date _____ Expiration Date _____

Physician _____ Telephone _____

Printed/Typed Name _____ Date _____

AUTHORIZATION FOR STAFF

The following staff members are authorized to administer the above prescribed medication(s) to the student:

_____

_____

_____

Principal's and/or Superintendent's Signature _____