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

_____ for student with diabetes only: self-administer diabetes care in accordance with Policy 5336

in accordance with the Doctor's prescription.

B. I will assume responsibility for safe delivery of the medication to school, except for diabetes medication student is permitted to possess pursuant to Policy 5336.

C. I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment, or if I wish to revoke this authorization.

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 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 named on this form.

_____ _____
Name of Student Address

_____ _____
School Class/Grade

I have prescribed the following medication _____
_____
_____

Beginning Date _____ Ending Date _____

Dosage, instructions, or precautions (including possible side effects): _____
_____
_____
_____

Report the following side effects to my office immediately _____
_____
_____
_____
_____
_____

I have prescribed the following treatment _____
_____
_____
_____
_____
_____

Beginning Date _____ Ending Date _____

For student with diabetes only:

_____ I authorize the student to attend to his/her diabetes care and management, in accordance with my order, during regular school hours and school sponsored activities. I have determined that the student is capable of performing diabetes care tasks.

_____ I do not authorize the student to attend to his/her diabetes care and management during regular school hours and school sponsored activities.

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):

_____

_____

_____
Director

1/15/15