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

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 foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

_____ _____

Signature of Parent Date

_____ _____

Home Telephone Work Telephone

To the Physician:

The Pinconning 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**	**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/treatment:

_____ _____

_____ _____

_____

Principal