AUTHORIZATION FOR NONPRESCRIBED MEDICATION OR TREATMENT

To the Parent:

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO USE NONPRESCRIBED MEDICATIONS 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 one or both)

_____ use or receive the following over-the-counter medication(s)

Medication: _____

Dosage: _____

Medication: _____

Dosage: _____

_____ self-administer such medication(s) in the presence 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

AUTHORIZATION FOR STAFF

The following staff members are authorized to administer the above-nonprescribed medication(s)/treatment(s):

_____

_____

_____
Principal

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. 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

AUTHORIZATION FOR THE POSSESSION AND USE OF ASTHMA INHALERS, EPI-PENS, OR PRESCRIBED EMERGENCY MEDICATION

This form must be provided to the principal assigned to the building of student attendance. Appropriate school staff should be notified.

Student Name: _____ Date: _____
Address: _____

Authorization is hereby given for the student named above to:

[ ] receive the prescribed medication indicated from the designated school personnel.
[ ] self-administer the prescribed medication as permitted by law.

Medication Name: _____

Dosage: _____

Date the administration is to begin: _____ Date the administration is to cease: _____

Adverse reactions that should be reported to the physician: _____

_____

Adverse reactions for unauthorized user: _____

_____

Procedure to follow in the event that medication does not produce the expected relief from student's asthma attack/allergic reaction: _____

_____

Other special instructions: _____

_____

Any additional information required should be attached to this form.

Physician and parent/guardian names, signature, and emergency phone numbers are required.

Physician Name: _____ Phone: _____

Signature: _____ _____
Date

Parent/guardian Name: _____ Phone: (Home) _____
(Work) _____
(Other) _____

Signature: _____ _____
Date

Received by _____ Date _____
Principal

Received by _____ Date _____
Nurse