AUTHORIZATION FOR MEDICATION OR TREATMENT
Board Policy # 5330

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

_____ _____ _____
Name of Student Telephone Date of Birth

_____
Address

_____ _____
School Homeroom

1. In accordance with the Doctor's prescription, I am requesting permission for my child named above to:(check one or both of the following) ____ use or receive medication ____ receive treatment

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

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 medication to be administered: _____

Medication dosage _____, route _____, is to be taken at the following times: _____

Instructions or precautions (including possible side effects): _____

_____

Treatment: _____

Beginning Date: _____ Expiration Date: _____

Physician Signature: _____ Telephone Number: _____

Printed/Typed Name: _____ Date: _____