

AUTHORIZATION FOR PRESCRIBED
MEDICATION/DRUG 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/drug 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/drug 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

LICENSED PRESCRIBER'S STATEMENT

To the Prescriber:

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.

I have prescribed the following medication _____

Beginning Date _____ Ending Date _____

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

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.

Prescriber'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

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AUTHORIZATION FOR THE POSSESSION AND USE OF ASTHMA INHALER/OTHER
EMERGENCY MEDICATION(S)

Student Name: _____ Date: _____

Address: _____

Authorization is hereby given for the student named above to:

- receive the prescribed medication indicated from the designated school personnel.
- keep emergency medication in his/her possession.
- 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 prescriber: _____

Adverse reactions for unauthorized user: _____

Procedure to follow in the event that medication does not produce the expected relief from student's asthma attack or other condition requiring emergency medication: _____

Other special instructions: _____

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

Prescriber name: _____ Phone: _____

Signature: _____ Date: _____

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

Signature: _____ Date: _____

Copies must be provided to Principal and to the School Nurse if one is assigned to the student's building.