



**AUTHORIZATION FOR MEDICATION OR TREATMENT
(If Applicable)**

School District: _____ Building: _____

To the Parent or Guardian:

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

Name of Student

Telephone

Address

Date of Birth

School

Room

A. I am requesting permission for my child named above to: (Check one or all)

_____ use or receive medication in accordance with a doctor's prescription

_____ receive treatment

_____ self-administer medication (e.g., Epi-pen or Inhaler only)

B. I will assume responsibility for safe delivery of the medication to school.

C. I will notify the school immediately if there is a change in the use of the medication or the prescribed treatment.

X _____
Signature of Parent/Guardian

Date _____

Primary Contact # _____ Additional Contact # _____

NOTE: ALL MEDICATIONS INCLUDING OVER-THE-COUNTER MEDICATION REQUIRES A DOCTOR'S
PRESCRIPTION OR THE COMPLETION OF PAGE 2 OF THIS FORM.

See back for Physician Statement



To the Physician:

The School District requires all of the following information before it will administer medication or treatment to

Student's Name

I have prescribed the following medication: _____

Medication is to begin _____, be taken at _____ and
end on _____. Dosage: _____

Instructions or precautions (Including possible side effects): _____

_____ This student is both capable and responsible to self-administer this medication
_____ with _____ without supervision.

Treatment: The following treatment is to be provided this student:

Beginning Date _____

Ending Date _____

Signature _____

Telephone _____

Printed/Typed Name _____

Date _____

AUTHORIZATION FOR STAFF

The following staff members are authorized to administer the above-prescribed medication(s) to the student (As per Board Policy 13.012 and Administrative Guideline 13.004):

