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_____ Date_____
Signature of Parent/Guardian

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 Physican:

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):

_____

_____