AUTHORIZATION FOR MEDICATION OR TREATMENT

To the Parent/Guardian or Adult Student:

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

_____	_____
Name of Student	Telephone
_____	_____
Address	Date of Birth
_____	_____
School	Room

Prescribed Medications

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

   _____ use or receive medication

   _____ receive treatment

I have the necessary authorization from my physician (see attached).

Prescribed medications must be accompanied by the *Authorization from the Physician Form* and must be in the original container.

Non-Prescribed Medications

I am requesting permission for my child (named above) to:

_____ use or receive medication

Type of Illness or Disease: _____

Name of Non-Prescribed Medication: _____

Dosage and Time Interval: _____

Special Instructions: _____

Side Effects: _____

Termination Date: _____

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

I will notify the school immediately if there is any change in the use of the medications or the prescribed treatment.

I release and agree to hold the Board of School Trustees, its officials, and its employees harmless from any and all liability for damages or injury directly or indirectly from this authorization.

I have read and understand the policy (attached) and fully understand the requirement that my child may never possess, self-administer, or provide medications (prescribed or non-prescribed) to another person (except for the reasons detailed in the policy) and that the school system will treat violations seriously.

Parent/Guardian Signature: _____

Date of Signature: _____

Home Telephone: _____

Work Telephone: _____

Emergency Telephone: _____

Authorization for Staff

The following staff members are authorized to administer the above-detailed medications to the student:

_____

_____

_____

PHYSICIAN STATEMENT

To the Physician:

The Board of School Trustees 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 to be administered to _____
Student

_____ _____
Medication Dosage

Medication is to be taken at the following times _____

Instructions or precautions (including possible side effects): _____

_____

_____

_____
Treatment

Beginning Date _____ Expiration Date _____

Physician _____ Telephone _____

Printed/Typed Name _____ Date _____

AUTHORIZATION FOR STAFF

The following staff members are authorized to administer the above-prescribed medication(s) to the student:

_____

_____

_____

_____
Principal

Name:

D.O.B:

Grade:

5330.02 F1

Complete ONLY WHEN a student needs to take medication during school hours.

AUTHORIZATION FOR THE POSSESSION AND USE OF ASTHMA INHALERS OR EPI-PEN

Authorization is hereby given for the student named on the reverse side to receive the medication marked below as indicated: (check any that apply)

_____ Asthma Inhaler

_____ Epi-Pen

_____ Diabetic Supplies

_____ Self-Carry the medication

_____ Self-Administer the prescribed medication as permitted by law

_____ Receive the prescribed medication indicated from designated school personnel

Medication Name:_____ Dosage:_____

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

_____

Adverse reactions for unauthorized user: _____

_____

_____

Other special instructions: _____

_____

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

Physician name: _____ Phone: _____

Physician Signature: _____ Date: _____

Parent/guardian name: _____ Phone: (Hm) _____
(Wk) _____
(Other) _____

Parent/guardian Signature: _____ Date:_____

A copy of this form must be provided to the student's Principal and the building School Nurse if self-carry permission of an inhaler or epi-pen is authorized by the student's physician.

8/04