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

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Student:___________________________________ **Grade**:___________________________

Beginning Date _____________________ Ending Date ______________________________

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

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I have prescribed the following treatment_______________________________________

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Beginning Date __________________________ Ending Date_________________________

For a 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):

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Principal