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