AUTHORIZATION FOR **PRESCRIBED** MEDICATION 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

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

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

D. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

_____ _____

Signature of Parent Date

_____ _____

Home Telephone Work Telephone