PARENT REQUEST AND AUTHORIZATION TO ADMINISTER PRESCRIBED MEDICATION OR TREATMENT

To the Parent/Guardian:
THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO USE PRESCRIBED MEDICATIONS OR TO RECEIVE TREATMENT IN SCHOOL.

_____ _____
Student Name Date of Birth

_____ _____
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. The medication must be received by the school in the container in which it was dispensed by the prescriber or licensed pharmacist.

C. I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment. A revised Licensed Prescriber's Statement must be submitted listing the changes.

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.

_____ _____
Parent/Guardian Signature Date

_____
Parent/Guardian Printed Name