AUTHORIZATION FOR MEDICATION OR TREATMENT

To the Parent or Adult Student:

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

Name of Student _____ Telephone _____

Address _____ Date of Birth _____

School _____ Room _____

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

   _____ use or receive medication

   _____ receive treatment

   in accordance with the Doctor's prescription.

2. I will assume responsibility for safe delivery of the medication to school, either by me or by my child.

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

4. 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 or indirectly from this authorization.

Signature of Parent or Adult Student _____ Date _____

Home Telephone _____ Work Telephone _____