Authorization for Medication

To the parent or adult student:

The following 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	Phone Number
Address	Date of Birth

1. I am requesting permission to my child named above to use/receive medication ________ parents initials here
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 prescribed treatment.
4. I release and agree to hold the Board of Education, its officials, the band boosters, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

Signature of Parent/Guardian	Date
Cell Phone Number	Email Address

Physician Statement

To the Physician:

The school district requires that all of the following information be provided before it will administer medication or treatment to the student named above.

I have prescribed the following medication: ____
____

Beginning date ________________________ Ending date __________________________

Dosage, Instructions, or precautions (including possible side effects): ____
____
____

I have prescribed the following treatment: - ____
____
____

Beginning date ________________________ Ending date __________________________

Physician's Signature ____ Telephone ______________________________

Printed Name ____ Date ___________________________________