PARENT REQUEST AND AUTHORIZATION TO ADMINISTER A 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	Class/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 medications(s) in my presence or that of an authorized staff member

In accordance with the authorized prescription.

B. I will assume responsibility for safe delivery of the medication/drug to school. (The medication/drug must be received by the District (i.e., the person authorized to administer the drug to the student) in the container in which it was dispensed by the prescriber or a licensed pharmacist.)
C. I will notify the school immediately if there is any change in the use of the medication/drug or the prescribed treatment. (You must submit to the District a revised licensed prescriber's statement, signed by the prescriber, if any of the information contained in the statement 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 form this authorization.

_____ _____
Signature of Parent* Date

_____ _____
Home Telephone Work Telephone

*Parent, guardian, or other person having care or charge of the student.

LICENSED PRESCRIBERS STATEMENT

To the prescriber:

The School District requires that all of the following information be provided before it will administer medication or treatment to the student named on this form.

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 _____

For student with diabetes only:

_____ I authorize the student to attend to his/her diabetes care and management, in Accordance with my order, during regular school hours and school sponsored activities. I have determined that the student is capable of performing diabetes care tasks.

_____ I do not authorize the student to attend to his/her diabetes care and management During regular school hours and school sponsored activities.

Prescriber's signature _____ Telephone_____

Printed/Typed Name _____ Date _____

AUTHORIZED FOR STAFF

The following staff members are authorized to administer the above-prescribed medication(s)/treatments(s):

_____

_____

_____

_____

_____

_____

_____

_____
Principal

2/15
NEOLA 2014