Student Name: _____

Date of Birth: _____

Licensed Prescriber's 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 wit 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: _____

Authorization for Staff

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

_____
_____

Authorization For Prescribed Medications 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   Date of Birth

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 an authorized staff member

_____   for student with diabetes only: self-administer diabetes care in accordance with Policy
        5336 in accordance with the Doctor's prescription.

B. I will assume responsibility for safe delivery of the medication/drug to school, except fc
    diabetes medication student is permitted to posses pursuant to Policy 5336.

C. I will notify the school immediately if there is any change in the use of the medication/drug
    or the prescribed treatment , or if I wish to revoke this authorization.

D. 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 from this authorization

_____   _____
Signature of Parent   Date

_____   _____
Home Telephone   Work Telephone