

AUTHORIZATION FOR 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. ALL SPACES MUST BE COMPLETED.

\_\_\_\_\_  
Name of Student

\_\_\_\_\_  
Grade

I am requesting permission for my child named above in accordance with the Doctor's prescription to:  
(Check all that apply)

\_\_\_\_\_ use or receive prescribed medication, dosage and times to be given below

\_\_\_\_\_

\_\_\_\_\_ receive prescribed treatment at the following times \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ self-administer prescribed medication(s) in my presence or that of an authorized staff member

Parent/Guardian Initial Required:

\_\_\_\_\_ I will assume responsibility for safe delivery of the medication/treatment supplies to school.

\_\_\_\_\_ I will notify the school immediately if there is a change in the dosage of the prescribed medication or procedure of the treatment.

\_\_\_\_\_ I give permission for the school nurse to contact the prescribing health care provider.

\_\_\_\_\_ 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.

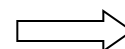
\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Home Telephone

\_\_\_\_\_  
Work Telephone

The School City of Hobart does not discriminate on the basis of race, creed, sex, color, national origin, religion, age, sexual orientation, marital status, genetic information or disability, including limited English proficiency.



PHYSICIAN STATEMENT

To the Physician:

The Corporation requires that all of the following information be provided before it will administer medication or treatment to the student named on the reverse side.

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/Typed Name \_\_\_\_\_ Date \_\_\_\_\_

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