

PRESCRIBED MEDICATION AUTHORIZATIONTo the Parent or Adult Student:

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT WHO POSSESS OR USES MEDICATIONS IN SCHOOL EACH OF WHICH MUST BE PRESCRIBED; ALL SPACES MUST BE COMPLETED.

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

\_\_\_\_\_  
Address Date of Birth \_\_\_\_\_

\_\_\_\_\_  
School Room \_\_\_\_\_

1. I am requesting permission for the student named above to possess and use medication according to the doctor's verification on this card.
2. I will assume responsibility for safe delivery of the medication to school, either by myself or by the student.
3. I will notify the school immediately if there is any change in the use of the medication.
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 \_\_\_\_\_

**PHYSICIAN STATEMENT**To the Physician:

The Board of Education urges you to schedule the taking of medications by students at times outside of school hours. When that is not possible, the possession and use of medications will be permitted, insofar as feasible, during school hours. Medication in pill form is preferable to liquids for use in school.

I verify that this medication must be taken by \_\_\_\_\_  
Student

Medication	Dosage	Route
_____	_____	_____

Medication is to be taken at the following times \_\_\_\_\_

Instructions or precautions (including possible side effects): \_\_\_\_\_

Beginning Date \_\_\_\_\_ Expiration Date \_\_\_\_\_

Physician \_\_\_\_\_ Date \_\_\_\_\_

Printed/Typed Name \_\_\_\_\_ Telephone \_\_\_\_\_