ELIDA LOCAL SCHOOLS

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 receive treatment in school. ALL SPACES MUST BE COMPLETED.

Student Name _____ Grade _____ DOB _____ Date _____

Address _____ Parent/Guardian phone #_____

Parent/Guardian

A. I am requesting permission for my child named above to: (Check all that apply)

_____ use or receive prescribed medication/treatment.

_____ self-administer prescribed medication in my presence or that of an authorized staff member.

B. I will assume responsibility for safe delivery of the medication/drug at school, except for diabetic students with medication are permitted to possess 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 or indirectly from this authorization.

Signature of Parent/Guardian _____ Date _____

Best Phone Number to Be Reached At: _____

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.

Medication Name _____

Diagnosis _____

Dosage, instructions, or precautions (including possible side effects): _____

_____

Beginning Date: _____ Ending Date: _____

Prescriber's Signature _____ Date _____

Printed/Typed Name _____ Telephone _____

4/29/15
10/4/17
8/15/18