KENSTON SCHOOLS

# AUTHORIZATION FOR PRESCRIBED MEDICATION 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 _____ Grade/Class _____

A. I am requesting permission for my child named above to:

1. use or receive prescribed medication/treatment and
2. self-administer the medication in the presence of an authorized staff member.

B. I will supply the medication in the original container and assume responsibility for the safe delivery of the medication to school.

C. I will notify the school immediately if there is any change in the use of the medication.

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 from this authorization.

Signature of Parent _____ Date _____

Home Telephone Number _____ Work Telephone _____

Cell Phone Number _____

***Please complete both sides of this form***

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***Please complete both sides of this form***

## AUTHORIZATION FOR PRESCRIBED MEDICATION OR TREATMENT

## PHYSICIAN STATEMENT

To the Physician:

The school district requires that all of the following information be provided before we will administer medication or treatment to a student.

_____ _____
Name of Student Address

_____ _____
School Class/Grade

I have prescribed the following medication:

Medication/Treatment: _____

Dosage: _____ Time: _____

Diagnosis/Reason student needs to take medication (optional): _____

_____

Beginning date: _____ Ending date: _____

Side effects to watch for and precautions when using this medication/treatment: _____

_____

_____

Physician's Signature: _____ Date: _____

Printed Name: _____ Phone: _____

5/2005