MADEIRA CITY SCHOOLS

PARENT REQUEST AND 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 TO RECEIVE TREATMENT IN SCHOOL. ALL SPACES MUST BE COMPLETED.

_____ _____
Name of Student Address

_____ _____ _____
School Grade 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 in my presence or that of an authorized staff member

B. I will assume responsibility for safe delivery of the medication/drug to school. The District (i.e. the person authorized to administer the drug to the student) must receive the medication/drug in the container in which it was dispensed by the prescriber or a licensed pharmacist.)

C. I will notify the school immediately if there is any change in the use of the medication/drug or the prescribed treatment. (You must submit to the District a revised licensed prescriber's statement, signed by the prescriber, if any of the information contained in the statement changes.)

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 Work Telephone

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.

_____ _____
Name of Student Address

_____ _____ _____
School Grade/Class Date of Birth

I am a licensed health professional authorized to prescribe drugs and I have prescribed the following medication to the above named student (Specify the name of the drug and under what conditions it is to be given)

_____

Date the administration of the drug is to begin _____

Date the administration of the drug is to cease _____

Specify the dosage of the drug to be administered, and the times or intervals at which each dosage of the drug is to be administered

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Specify any special instructions for administration of the drug, including sterile conditions and storage

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Report the following side effects (i.e. severe adverse reactions to my office immediately

_____

Prescriber's Signature _____ Phone Number_____

Printed Name _____ Date _____

AUTHORIZATION FOR STAFF

The following staff members are authorized to administer the above prescribed

medication(s)/treatment(s): _____

Principal's Signature _____