AUTHORIZATION FOR MEDICATION/TREATMENT

To the Parent:
The following information is necessary for any student to possess or use prescribed medications or to receive treatment in school. **PLEASE COMPLETE ALL SPACES OR THE MEDICATION/TREATMENT WILL NOT BE ADMINISTERED.**

_____ _____
Name of Student parent daytime phone #

_____
Date of Birth

_____ _____
School Room/ Teacher/ Grade

- I request permission for my child named above to: (Check all that apply)
  _____ use or receive treatment
  _____ self-administer medication in the presence of school personnel in accordance with the doctor's prescription.
- I will assume responsibility for safe delivery of the medication to school.
- I will pick up **ALL** medications for my child at the end of the school year as I understand the school is not allowed to send medication home with my child.
- **I understand that all medication left at the school at the end of the school year will be discarded by the school nurse if I do not pick it up by the last day of school.**
- I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment.
- I release and agree to hold the school board, school officials, and school employees harmless from and not responsible for any and all liability for damages or injury resulting directly or indirectly from this authorization.

_____ _____
Signature of Parent Date

_____
Home Telephone

_____
Work Telephone

PHYSICIAN STATEMENT

(Form must be completed by physician for prescription meds to be administered at school.)

To the Physician:

South Spencer School Corporation requires all of the following information before it will

administer medication or treatment to _____.
Student's Name

I have prescribed the following medication _____
_____

Medication is to begin _____ (date), be taken at _____ (time), and end on _____ (date).

Instructions or precautions (including possible side effects):
_____
_____
_____

____ This student is both capable and responsible to self-administer this medication with supervision.

Treatment: The following treatment is to be provided to this student:
_____
_____
_____

Order Beginning Date: _____ Order Expiration Date: _____

Signature_____ Telephone_____

Printed/Typed Name_____ Date_____

AUTHORIZATION FOR STAFF

The school nurse and designated staff members are authorized to administer the above prescribed medications/treatments to the student listed above.

_____
Principal

MEDICATION ADMINISTRATION FORM
SOUTH SPENCER SCHOOL CORPORATION

The following form needs to be turned in to the school office if your child is to be given medication by school personnel during school hours. **A new permission form must accompany each new medication the student is to be given at school.**

I request that school staff members administer medication to my child during school hours in accordance with the instructions I have written below. (No dosage may be given beyond the recommended dosage for over the counter medications.):

Child's Name:_____

School Name:_____

Name of Medication:_____

Purpose of Administration:_____
_____

Dosage:_____

Time or times of administration:_____

Termination date for administered medication:_____

Unusual side effects to watch for:_____
_____

Any special instructions:_____
_____

_____ _____
Parent/Guardian Signature Date