Finneytown Local School District

5330 F1

AUTHORIZATION FOR PRESCRIBED MEDICATION OR TREATMENT

To the Physician:

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/Teacher

I have prescribed the following medication: _____
Name as it appears on bottle

Dosage: _____ Frequency:_____ Time(s):_____

Beginning Date_____ Ending Date_____

Side Effects: _____

_____

Special Instructions: _____

_____

_____ _____
Physician's Signature Telephone Number

_____ _____
Printed/Typed Name Date

To the Parent(s):
THE FOLLOWING MUST BE COMPLETED FOR ANY STUDENT TO USE PRESCRIBED MEDICATION OR TO RECEIVE TREATMENT IN SCHOOL.

A. I am requesting permission for my child to: (Initial all that apply)
   _____ Use or receive prescribed medication

   _____ Receive prescribed treatment

   _____ Self-administer prescribed medication(s) in my presence or that of an authorized staff member

   NOTE: All that apply MUST be in accordance with the Physician's prescription.

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

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

D. I release and agree to hold the Board of Education, its officials, and its employees harmless from any liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

_____ _____
Signature of Parent Date

_____ _____
Home Telephone Other Telephone Number