Prescribed Medication Authorization

_____
NAME OF STUDENT

Parent to Complete

Purpose: To permit students to possess and use prescribed medications during school hours when regular attendance at school would be impossible without the medication.

Address **Telephone**

Date of Birth **School** **Room**

To the Parent or Guardian:
THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT WHO POSSESSES OR USES PRESCRIBED MEDICATION IN SCHOOL; BOTH THE PARENT AND PHYSICIAN PORTIONS OF THIS FORM MUST BE COMPLETED.

1. I am requesting permission for the student named above to possess and use medication according to the doctor's verification on this card.
2. I will assume responsibility for the safe delivery of the medication to school, either by myself or by the student.
3. I will notify the school immediately if there is any change in the use of the medication.
4. I authorize Immaculate Conception personnel to communicate with my child's health care provider as necessary concerning the use of this medication.
5. 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 or Guardian **Date**

Home Telephone **Work Telephone**

Physician to Complete

To the Physician:

Immaculate Conception School urges you to schedule the taking of medication by students at times outside of school hours. When that is not possible, the possession and use of medications will be permitted, insofar as feasible, during school hours. Medication in pill form is preferable to liquids for use in school.

I verify that this medication must be taken by _____
during school hours: (Student's Name)

(Medication) (Dosage) (Route)

Medication is to be taken at the following times_____
Instructions of precautions (including possible side effects):

Beginning date _____ Expiration Date_____

Physician _____
Signature Date

Printed Name Telephone Number

Address

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