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 _____

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(s) in my presence or that of an authorized staff member

in accordance with the authorized prescription.

B. I will assume responsibility for safe delivery of the medication/drug to school. (The medication/drug must be received by the District (i.e., the person authorized to administer the drug to the student) 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 _____

*Parent, guardian, or other person having care or charge of the student.

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 Class/Grade

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) _____
_____
_____

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 _____
_____
_____

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

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

_____
_____
_____
_____
_____

Prescriber's Signature _____ Telephone _____

Printed/Typed Name _____ Date _____

OSNABURG LOCAL SCHOOLS
MEDICATION AUTHORIZATION

To the Parent or Guardian:

To comply with your request to administer the medication to your child as prescribed by his/her physician, you must agree to the following:

1. Your written permission must be on file at your child's school.

2. **You are responsible for the safe delivery of the medication in the container from the pharmacy to the school. This rule also applies to over-the-counter medicine.**

3. You agree to notify the school immediately if there is a change in the use of the medication.

4. **If the medication is a prescription you understand that we must have written directions from the physician.** The medication also needs to be in the original prescription bottle. If the dosage and times are changed we will need an updated letter from the physician.

5. Liquid medication shall be the responsibility of the parent and will be administered only at the principal's discretion.

6. You release the Board of Education and it's employees from any and all liability for damage or injury resulting directly or indirectly from this authorization.

7. You also give permission to school personnel to contact the physician with questions regarding the medication order and to send progress reports or to clarify information.

PARENT'S AUTHORIZATION TO GIVE MEDICATION

School_____ Teacher_____

I have read and understand the above agreement.

I hereby request and give my permission for an Osnaburg Local staff member to administer

_____(# of tablets) of _____(name of drug)

at _____(time) as prescribed by_____(doctor)

to my child:_____. Child's birth date:_____

Parent/Guardian Signature _____

Address _____

Phone (home)_____ (work)_____ Today's date_____