## **Authorization For PRESCRIBED Medication Or Treatment At School**

**IMPORTANT** - The following information is necessary for any student to use prescribed medications or treatments at school in accordance to the Negaunee Public School Board Policy and Handbook. This form must be fully completed and signed by the parent/guardian and physician in order to administer any prescribed medication/treatment at school.

Nedication/Treatment:	Student Name Grade/Teacher  Authorization is hereby given for the above named to receive or use the following prescribed medications, emergency medications, or treatments.		
Clark   Cla	1. Medication/Treatment:	Dose:	Administration Time:
Skin (Topical)	Route: □Mouth (Oral)	□Injection (Shot): □Subcutaneous □Intramuscular	
Special Instruction:   Possible Side Effects:   Starting Date:   Ending Date:	□Inhalation (Lungs)	□Ear: □Left □Right	□Peg Tube
Special Instruction:	□Skin (Topical)	□Nose: □Left □Right	□Rectal
Possible Side Effects: Starting Date: Ending Date:    Dose: Administration Time:	□Eye: □Left □Right	□Other:	
2. Medication/Treatment:	Special Instruction:		
Route:   Mouth (Oral)	Possible Side Effects:	Starting Date:	Ending Date:
Route:   Mouth (Oral)			
□Inhalation (Lungs) □Ear: □Left □Right □Peg Tube □Skin (Topical) □Nose: □Left □Right □Rectal □Eye: □Left □Right □Other: □Special Instruction: □Possible Side Effects: Starting Date: Ending Date: □SIGNATURES:  I have discussed this with my physician and give permission for my child to receive the listed medication. I authorize school personnel to administer the prescribed medication, if necessary. I will assume responsibility for safe delivery of the medication to school. I will notify the school immediately if there is any change in the use of medication or prescribed treatment. Our physician has instructed that the medication listed should be administered in the above dosage listed. I release and agree to hold the Board of Education, it's officials, and it's employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.  Parent Signature: Date: □Date: □Dat	2. Medication/Treatment:	Dose:	Administration Time:
□Inhalation (Lungs) □Ear: □Left □Right □Peg Tube □Skin (Topical) □Nose: □Left □Right □Rectal □Eye: □Left □Right □Other: □Special Instruction: □Possible Side Effects: Starting Date: Ending Date: □SIGNATURES:  I have discussed this with my physician and give permission for my child to receive the listed medication. I authorize school personnel to administer the prescribed medication, if necessary. I will assume responsibility for safe delivery of the medication to school. I will notify the school immediately if there is any change in the use of medication or prescribed treatment. Our physician has instructed that the medication listed should be administered in the above dosage listed. I release and agree to hold the Board of Education, it's officials, and it's employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.  Parent Signature: Date: □Date: □Dat	Route: □Mouth (Oral)	□Injection (Shot): □Subcutaneous	s □Intramuscular
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Describing Physician Signature:    Special Instruction:	,	_	•
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→ Prescribing Physician Signature: Date:	<ul> <li>I have discussed this with my physic</li> <li>I authorize school personnel to admit</li> <li>I will assume responsibility for safe</li> <li>I will notify the school immediately</li> <li>Our physician has instructed that the</li> <li>I release and agree to hold the Board</li> </ul>	nister the prescribed medication, if necessary delivery of the medication to school. if there is any change in the use of medication medication listed should be administered in I of Education, it's officials, and it's employe	n or prescribed treatment. the above dosage listed. es harmless from any and all liability
	→Parent Signature:		Date:
Physician Name (printed):  Phone #:	→ Prescribing Physician Signatu	ıre:	Date:
	Physician Name (printed):	P	hone #: