

# MEDINA CITY SCHOOLS

## AUTHORIZATION FOR PRESCRIBED MEDICATION 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 for my child named above to: (Check all that apply)

Use or receive prescribed medications

Receive prescribed treatment

Name of medication: \_\_\_\_\_

Dosage to be administered: \_\_\_\_\_

Time or intervals at which each dosage is to be administered: \_\_\_\_\_

Date the administration of medication is to begin: \_\_\_\_\_

Date the administration of medication is to cease: \_\_\_\_\_

Any severe adverse reactions that should be reported to the physician:

\_\_\_\_\_

One or more telephone numbers at which the physician can be reached in an emergency:

\_\_\_\_\_

Special instructions including sterile conditions and storage: \_\_\_\_\_

Name of Physician: \_\_\_\_\_

Address of Physician: \_\_\_\_\_

Date of this statement: \_\_\_\_\_

Signature of Physician: \_\_\_\_\_

- B. I will assume responsibility for safe delivery of the medication to school. The medication must be in its original container, labeled with the date. If it is prescription medication it must also be labeled with the student's name and exact dosage to be administered.
- 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 and all liability for damages or injury resulting directly or indirectly from this authorization.

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Home Phone

\_\_\_\_\_  
Work Phone