BRANDON SCHOOL DISTRICT

PARENT/GUARDIAN AUTHORIZATION FOR MEDICATION OR TREATMENT

To the Parent/Guardian:
THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO POSSESS OR USE PRESCRIBED MEDICATIONS OR TO RECEIVE TREATMENT IN SCHOOL. ALL SPACES MUST BE COMPLETED.

_____ _____
Name of Student Telephone Number

_____ _____
Address Date of Birth

_____ _____
School Room

1. I am requesting permission for my child named above to: (Check one or both)
   _____ Use or receive medication
   _____ Receive treatment in accordance with the Doctor's prescription.
2. I will assume responsibility for safe delivery of prescribed medication to school, **(parent or designated adult only).**
3. I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment.
4. 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/Guardian Date

_____ _____
Home Telephone Work Telephone

PHYSICIAN STATEMENT

To the Physician:
The Board of Education urges you to schedule, to the extent possible, medication or treatment of a student outside of school hours. When that is not possible, prescribed medications and/or treatment will be permitted, insofar as feasible, during school hours. Medication in pill form is preferable to liquids for use in school.

I have prescribed the following to be administered to _____
Student

_____ _____
Medication Dosage

Medication is to be taken at the following times _____

Instructions or precautions (including possible side effects) _____

_____
Treatment

Beginning Date _____ Expiration Date _____

Physician Signature _____ Telephone _____

Printed/Typed Name of Physician _____ Date _____

AUTHORIZATION FOR STAFF

The following staff members are authorized to administer the above-prescribed medication(s) to the student:

_____

_____

Principal _____