Niles Community Schools

AUTHORIZATION FOR PRESCRIBED MEDICATION OR TREATMENT

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO USE PRESCRIBED MEDICATIONS OR TO RECEIVE TREATMENT IN SCHOOL. ALL SPACES MUST BE COMPLETED.

Student Name: _____ Address: _____
Last First

School Attending: _____ Current Grade: _____ Date of Birth: _____

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 doctor's prescription.
B. I will assume responsibility for safe delivery of the medication to school.
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 foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

Parent/Guardian Signature: _____ Date: _____

Home Phone: _____ Cell Phone: _____

PHYSICIAN STATEMENT

Niles Community Schools requires the following information before it will administer medication or treatment to the student.

Student Name: _____ Address: _____
Last First

I have prescribed the following medication: _____

_____

Beginning Date: _____ Ending Date: _____

Dosage, instructions, or precautions: _____

_____

Report the following side effects to my office immediately: _____

_____

Physician's Signature: _____ Phone: _____

Printed Physician's Name: _____ Date: _____

AUTHORIZATION FOR STAFF

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

_____

Principal Signature: _____ Date: _____