Coldwater Community 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 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(s) 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.

_____ _____

Signature of Parent Date

_____ _____

Home Phone Work Phone

To the Physician

*The School District requires that **all** of the following information be provided **before** it will administer medication or treatment to the student.*

I have prescribed the following medication to the above listed student:

_____

Beginning Date: _____ Ending Date:_____

Dosage, Instructions, or Precautions:_____

_____

Report the following side effects to my office immediately:_____

_____

Physician's Signature:_____ Phone:_____

Printed Name:_____ Date:_____

Authorization for Staff

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

Principal Signature:_____