AUTHORIZATION FOR PRESCRIBED MEDICATION OR TREATMENT

To the Parent/Guardian:

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 Grade

I am requesting permission for my child named above in accordance with the Doctor's prescription to: (Check all that apply)

_____ use or receive prescribed medication, dosage and times to be given below

_____

_____ receive prescribed treatment at the following times_____

_____

_____ self-administer prescribed medication(s) in my presence or that of an authorized staff member

Parent/Guardian Initial Required:

_____ I will assume responsibility for safe delivery of the medication/treatment supplies to school.

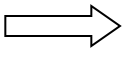
_____ I will notify the school immediately if there is a change in the dosage of the prescribed medication or procedure of the treatment.

_____ I give permission for the school nurse to contact the prescribing health care provider.

_____ 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 Corporation requires that all of the following information be provided before it will administer medication or treatment to the student named on the reverse side.

I have prescribed the following medication _____

_____

_____

Beginning Date _____ Ending Date _____

Dosage, instructions, or precautions (including possible side effects): _____

_____

_____

_____

I have prescribed the following treatment _____

_____

_____

_____

_____

_____

Beginning Date _____ Ending Date _____

Physician's Signature _____ Telephone _____

Printed/Typed Name _____ Date _____

AUTHORIZATION FOR NONPRESCRIBED MEDICATION OR TREATMENT

To the Parent/Guardian:

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO USE NONPRESCRIBED MEDICATIONS IN SCHOOL. ALL SPACES MUST BE COMPLETED.

_____ _____
Name of Student Grade

I am requesting permission for my child named above to receive the following over-the-counter medication(s)

Medication: _____

Dosage: _____

Medication: _____

Dosage: _____

Parent/Guardian Initial Required:

_____ I will assume responsibility for safe delivery of the medication to school office.

_____ I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment.

_____ Our physician has instructed that this medication should be administered in the above designated dosage.

_____ I release and agree to hold the Board of School Trustees, 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

The School City of Hobart does not discriminate on the basis of race, creed, sex, color, national origin, religion, age, sexual orientation, marital status, genetic information or disability, including limited English proficiency.