#### BENJAMIN LOGAN LOCAL SCHOOL DISTRICT

### AUTHORIZATION FOR PRESCRIBED MEDICATION OR TREATMENT

Name of Student		Grade	Address			
Sch	ool Building					
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.					
В.	I will assume responsibility for safe delivery of the medication/drug to school. (The medication/drug must be received by the District (i.e., the person authorized to administer the drug to the student) in the container in which it was dispensed by the prescriber or a licensed pharmacist.)  I will notify the school immediately if there is any change in the use of the medication/drug or the prescribed treatment. (You must submit to the District a revised licensed prescriber's statement, signed by the prescriber, if any of the information contained in the statement changes.)					
C.						
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			

# ONLY MEDICATION IN ITS ORIGINAL CONTAINER LABELED WITH THE DATE, THE STUDENT'S NAME, AND THE EXACT DOSAGE WILL BE ADMINISTERED.

## PLEASE REMEMBER:

- You must provide the quantity of medication needed at school and necessary refills. You need to pick up any leftover medication within <u>1 week</u> after the end of the school year. Otherwise, the medication will be destroyed.
- A revised form must be provided if any information changes.
- Educate your child concerning proper administration techniques and time intervals as well as potential dangers and side effects associated with the medication.

# LICENSED PRESCRIBER' STATEMENT

To the Prescriber:				
The Benjamin Logan School District requires medication or treatment to the student.	that all of the fol	lowing information be provided before it will administe		
Name of Student	Grade	Address		
School Building				
I am a licensed health professional authorized to	prescribe drugs, a	nd I have prescribed the following medication to the above		
named student (specify the name of the drug)				
Date the administration of the drug is to begin _				
Date the administration of the drug is to cease _				
Specify the dosage of the drug to be administ	ered, and the time	es or intervals at which each dosage of the drug is to b		
administered:				
Specify any special instructions for administration	on of the drug, incl	uding sterile conditions and storage		
Report the following side effects (i.e., severe ad	verse reactions) to	my office immediately		
Prescriber's Signature		Phone		
Printed/Typed Name		Date		
The following staff members are authorized	I to administer the	e above-prescribed medication(s)/treatment(s):		
		Principal		