Whiteford Agricultural School District

of the Counties of Lenawee and Monroe, Michigan

"Home of the Bobcats"

6655 Consear Road
Ottawa Lake, MI 49267
734-856-1443

Superintendent/Business Office Fax: 734-854-6463
Middle School/High School Fax: 734-856-2564
Elementary School Fax: 734-856-4724

AUTHORIZATION FOR PRESCRIBED AND/OR NON-PRESCRIBED MEDICATION OR TREATMENT

To the Parent:

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO USE **PRESCRIBED OR NON-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.

_____ Use or receive the following over-the-counter (non-prescribed) medication(s):

Medication: _____

Dosage: _____

Medication: _____

Dosage: _____

_____ Self-administer such over-the-counter medication(s) in my presence or that of an authorized staff member.

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. *(Note: Any physician directed change must have a revised Physician Statement.)*

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 _____

Printed/Typed Name _____

Home Telephone _____ Work Telephone _____

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PHYSICIAN STATEMENT

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.

Name of Student _____ Address _____

School _____ Grade _____

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 _____

Printed/Typed Name _____ Date _____

AUTHORIZATION FOR STAFF

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

_____

_____

_____
Principal