ELMWOOD LOCAL SCHOOLS

Authorization for the Administration of Medication

TO BE COMPLETED BY PARENT/GUARDIAN

NAME OF STUDENT _____ GRADE _____

TELEPHONE NUMBER WHERE PARENT/GUARDIAN CAN BE REACHED IN CASE OF AN EMERGENCY:

HOME _____ WORK _____ CELL _____

** I HEREBY REQUEST AND GIVE PERMISSION TO THE APPROPRIATE SCHOOL PERSONNEL TO ADMINISTER THE FOLLOWING PRESCRIBED MEDICATION TO MY CHILD IN ACCORDANCE WITH MY PHYSICIANS DIRECTIONS AS STATED BELOW.

I GIVE PERMISSION TO THE ELMWOOD LOCAL SCHOOL TO EXCHANGE INFORMATION REGARDING MY SON/DAUGHTER WITH THE BELOW LISTED PHYSICIAN.

FURTHER, WE (I), THE UNDERSIGNED, WILL NOTIFY THE SCHOOL IMMEDIATELY IF WE CHANGE MEDICAL PROVIDERS OR MEDICATION OR TERMINATE THE USE OF THIS MEDICATION FOR ANY REASON. WHEN MEDICATION HAS BEEN DISCONTINUED, ANY REMAINING MEDICATION MUST BE PICKED UP BY THE PARENT WITHIN TWO (2) WEEKS AFTER DISCONTINUATION OR THE MEDICATION WILL BE DISCARDED BY SCHOOL PERSONNEL. PARENTS MUST PICK UP MEDICATION ON THE LAST DAY OF SCHOOL OR IT WILL BE DISCARDED.

MY SIGNATURE BELOW INDICATES I HAVE READ AND UNDERSTAND THE POLICY STATEMENT OF THE ELMWOOD BOARD OF EDUCATION #5330 FOUND ON THE REVERSE SIDE OF THIS FORM.

_____ _____

SIGNATURE OF PARENT OR GUARDIAN DATE

TO BE COMPLETED BY YOUR PHYSICIAN

_____ IS UNDER MY CARE AND SHOULD RECEIVE THE FOLLOWING

MEDICATION AS PRESCRIBED:

NAME OF MEDICATION _____

DOSAGE _____

TIME OF ADMINISTRATION _____

DATE TO BEGIN _____ DATE TO END _____

SPECIFIC INSTRUCTIONS FOR ADMINISTRATION _____

_____

_____

POSSIBLE SIDE EFFECTS TO WATCH FOR _____

_____

SIGNATURE OF PHYSICIAN _____ DATE _____

TELEPHONE NUMBER _____