HOLY CROSS LUTHERAN SCHOOL

AUTHORIZATION FOR PRESCRIBED MEDICATION OR TREATMENT

To the Parent:

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

_____
Name of Student

A. I am requesting permission for my child named above to: (Check all that apply).
B. _____Receive prescribed treatment in accordance with a Doctor's prescription

   Name of Medication _____

   Dosage and Schedule:_____

   Duration: _____

   _____Self-administer prescribed medication(s) in my presence or that of an authorized staff member, in accordance with the Doctor's prescription.

C. I will assume responsibility for safe delivery of the medication to school.
D. I will notify the school immediately if there is any change in the use of the medication or treatment
E. I release and agree to hold Holy Cross Lutheran Church and School, it's 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.
F. I understand that the medication must be prescribed for the student specifically and it must be in the original container.

_____ _____
Signature of Parent Date

_____ _____
Mobile or home Telephone Numbers Work Telephone number

AUTHORIZATION FOR STAFF

The following staff members are authorized to administer the above mentioned medication(s) or treatment(s).

_____ _____

_____ _____

_____
Principal