AUTHORIZATION FOR PRESCRIBED MEDICATION OR TREATMENT
Physician Statement

WILLIAMSBURG ELEMENTARY SCHOOL
839 Spring Street Williamsburg, Ohio 45176
Phone 513-724-2241 Fax 513-724-3902

Section to be completed by Physician:

The School District requires that all of the following be provided before it will administer medication or treatment to the student.

Student: _____

Date of Birth: _____

MEDICATION: _____

Beginning Date: _____

Ending Date: _____

Dosage: _____

Time: _____

Instructions and/or precautions:

_____

_____

Report the following side effects to my office immediately:

_____

_____

Physician Name _____

Physician Phone _____

Physician Signature_____

AUTHORIZATION FOR STAFF

The following staff members are authorized to administer the above prescribed medication/treatment:

_____

_____

PRINCIPAL SIGNATURE

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Section to be completed by parent:

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

Student: _____

Address:_____

Date: _____

Medication: _____

- **I am requesting permission for my child named above to (check all that apply):**

❑ Use or receive prescribed medication in accordance with doctor's prescription
❑ Receive prescribed treatment in accordance with doctor's prescription.
❑ Self-administer prescribed medication in my presence or that of an authorized staff member in accordance with the doctor's prescription.

- **I will assume responsibility for safe delivery of the medication to school.**
- **I will notify the school immediately if there is a change in the use of the medication or the prescribed treatment.**
- **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 in directly or indirectly from this authorization.**

Parent Signature: _____Date: _____

Phone: _____

PHYSICIAN STATEMENT MUST BE COMPLETED ON REVERSE SIDE