BENZIE CENTRAL SCHOOLS

Authorization for Prescribed Medication or Treatment

To the Parent/Guardian:

The following information is necessary for any student to use 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

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.

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

_____ Home/Cell Phone

_____ Work Phone

1. _____ Medication

2. _____ Medication

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