Prescribed Medication Authorization/Food Allergy Action Plan

Return to School if and when Needed!

September 2016

The following information is necessary for any student who possess or uses medications in school, each of which must be prescribed. All spaces must be completed. Only medication in its **original container**, labeled with the **date of the prescription**, the **students name**, and the **exact dosage** will be administered.

Students Name____Phone________________________

Address____ Birth Date_____________________

School____ Grade_________________________

Prescription to be administered accordingly: Time_______________________________________

Dosage ____________________________________

1. I am requesting permission for the student named above to possess and use medication according to the doctor's verification.
2. I will assume responsibility for **safe delivery** of the medication to school.
3. I will **notify the school** immediately if there is any change in the use of the medication.
4. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

Parents Signature____ Date_______________________

Home Phone______________________________Work Phone _______________________________

Over for Food Allergy Action Plan ⟶