



## PHYSICIAN STATEMENT

To the Physician:

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

Name of Student: \_\_\_\_\_

Address: \_\_\_\_\_

*The Greenspire School*

\_\_\_\_\_ School Grade

I have prescribed the following medication[s]:

Medication[s]:	Dosage:	Instructions and Precautions:

Physician's Signature: \_\_\_\_\_

Telephone: \_\_\_\_\_

Printed/Typed Name: \_\_\_\_\_

Date: \_\_\_\_\_

**KINDLY EMAIL OR FAX THIS FORM BACK TO THE GREENSPIRE SCHOOL**

**Fax: 231-525-2214**

**hsoffice@greenspireschool.org**



**AUTHORIZATION FOR PRESCRIBED AND/OR  
UNPRESCRIBED MEDICATION OR TREATMENT**

Dear Parent,

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

Name of Student: \_\_\_\_\_

Address: \_\_\_\_\_

School: THE GREENSPIRE SCHOOL

Grade: \_\_\_\_\_

A. I am requesting permission for my child named above to: (Check all that apply)

- \_\_\_\_\_ use or receive prescribed and/or unprescribed medication
- \_\_\_\_\_ receive prescribed and/or unprescribed treatment
- \_\_\_\_\_ self-administer prescribed and/or unprescribed medication(s) in my presence or that of an authorized staff member

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 Directors, 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.

Name of Medication	Dosage:	Time Taken:

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Home telephone

\_\_\_\_\_  
Work phone