AUTHORIZATION FOR PRESCRIBED MEDICATION OR TREATMENT

Dear Parent,

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: The Greenspire School

Student 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 in 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 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

_____ _____

Cell Phone Number Secondary Phone Number

THE GREENSPIRE MIDDLE SCHOOL

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: _____

School: The Greenspire School Student grade: _____

I have prescribed the medication(s):

Name of Medication:	Dosage/Frequency:	Instructions/Precautions:

_____

Physician's Signature Date

_____ _____

Printed/Typed Name Telephone Number

KINDLY EMAIL OR FAX THIS FORM BACK TO THE GREENSPIRE MIDDLE SCHOOL
FAX: 866-805-1327
office@greenspireschool.org