*READING COMMUNITY SCHOOL*
*READING, MICHIGAN 49274*

AUTHORIZATION FOR MEDICATION OR TREATMENT

To the Parent or Guardian of:

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO USE PRESCRIBED MEDICATIONS IN SCHOOL. ALL SPACES MUST BE COMPLETED.

| ______________________________ | ______________________________ |
|---|---|
| Name of Student | Telephone |
| ______________________________ | ______________________________ |
| Medication | Dosage |

Medication is to be taken at the following times ______________________________

Instructions or precautions (including possible side effects): ______________________________

______________________________________________________________

______________________________________________________________

1. I give permission for my child named above to receive medication from school personnel.
2. I will assume responsibility for safe delivery of the medication to school, for my child by myself or transported by bus personnel according to school policy.
3. I will notify the school immediately if there are any changes in the use of the medication or the prescribed treatment.
4. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability for damages for injury resulting directly or indirectly from this authorization.

| ______________________________ | ______________________________ |
|---|---|
| Signature of Parent or Adult Student | Date |
| ______________________________ | ______________________________ |
| Home Telephone | Work Telephone |

Beginning Date ____________________ Expiration Date ____________________

Physician ____________________ Telephone ____________________

Physician Address ______________________________________________