SASED

PHYSICIAN AUTHORIZATION
FOR
ADMINISTRATION OF TREATMENT

(Completed by physician) **DATE:**_____

This child _____ **is under my medical care for** _____
and is required to have the follow treatment administered during school hours.

****

Treatment order_____

_____

Equipment_____

Frequency of Treatment_____

Side effects/ Precaution_____

****

Physician Signature_____
Printed Physician Name_____
Address_____
Emergency Telephone #_____

****

TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN:
I give permission for my child to receive the above medication/ treatment(s) as directed by the physician. I request that authorized school personnel give the above medication and/ or treatment ordered by the physicians stated above, according to the directions given. I authorize a representative of the school to exchange information about this medication and/ or treatment with the above named health care provider, as needed. I waive any claims against SASED, its employees and agents, arising from the administration or attempts at administration of said medication/ treatment. I will provide all supplies needed to do the treatment. I will notify the school in writing if the treatment is discontinued.

Date:_____
Parent Signature_____
Address_____
City_____**State**_____**Zip**_____
Telephone (hm)_____**(wk)**_____**(fax)**_____