PHYSICIAN AUTHORIZATION FOR ADMINISTRATION OF TREATMENT

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

This child _____ is under my medical care for _____ and is required to have the following 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)_____(cell)_____