PERMISSION FOR ADMINISTERING SPECIAL HEALTH CARE TREATMENTS/PROCEDURES/MEDICATIONS (PRESCRIPTION & OTC)

I hereby authorize the school nurse/staff to administer the following treatment/procedure/medication to:

Student Name: _____

Address: _____

Elementary Middle High Headstart/Preschool
(Circle one)

Grade/Teacher: _____

1. Name of treatment/procedure/medication:

   Student may self-administer inhaler: _____
   Parent/Guardian signature

2. Time schedule/indication for treatment/procedure/medication:

3. Precautions, possible adverse reactions, interventions and instructions:

This treatment will begin on _____ and terminate on _____.

_____ _____
Parent/Guardian Signature Date

_____ _____
Health Care Provider Signature Date

Parent/Guardian will provide supplies for needed treatment/procedure/medication. Treatment/procedure/medication directions will be renewed each school year and amended as necessary during the school year. Student may be transported to local health care facility if emergency treatment/procedure/medication is indicated or has been administered.