WCSCC
WAYNE COUNTY SCHOOLS **CAREER CENTER**
Education at its Finest

Kip Crain, Ph.D., Superintendent
Mary A. Workman, Treasurer
Matt Brown, Principal

518 West Prospect Street
Smithville, Ohio 44677

High School: 330-669-7000
High School Fax: 330-669-7001
Adult Education: 330-669-7070
Adult Ed Fax: 330-669-7071
Website: www.wcscc.org

AUTHORIZATION FOR PRESCRIBED MEDICATION/DRUG OR TREATMENT

To the Parent:

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO USE PRESCRIBED MEDICATIONS OR TO RECEIVE TREATMENT IN SCHOOL. ALL SPACES MUST BE COMPLETED. PLEASE SEND ANY MEDICATION IN THE ORGINAL PRESCRIPTION BOTTLE.

_____ _____
Name of Student Address

_____ _____
School 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 that of an authorized staff member
_____ for student with diabetes only: self-administer diabetes care in accordance with Policy 5336
in accordance with the Doctor's prescription.

B. I will assume responsibility for safe delivery of the medication/drug to school, except for diabetes medication student is permitted to possess pursuant to Policy 5336.

C. I will notify the school immediately if there is any change in the use of the medication/drug or the prescribed treatment, or if I wish to revoke this authorization.

D. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability for damages or injury resulting directly from this authorization.

_____ _____
Signature of Parent Date

_____ _____
Home Telephone Work Telephone

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LICENSED PRESCRIBER'S STATEMENT

To the Prescriber:

The School District requires that all of the following information be provided before it will administer medication or treatment to the student named on this form.

STUDENT NAME (FIRST AND LAST): _____

STUDENT ADDRESS: _____

STUDENT DATE OF BIRTH: _____

I have prescribed the following medication/treatment_____

_____

_____

Beginning Date _____ Ending Date _____

Dosage, instructions, or precautions (including possible side effects): _____

_____

_____

_____

For student with diabetes only:

_____ I authorize the student to attend to his/her diabetes care and management, in accordance with my order, during regular school hours and school sponsored activities. I have determined that the student is capable of performing diabetes care tasks.

_____ I do not authorize the student to attend to his/her diabetes care and management during regular school hours and school sponsored activities.

Prescriber's Signature _____ Telephone _____

Printed/Typed Name _____ Date _____

AUTHORIZATION FOR STAFF

The following staff members are authorized to administer the above-prescribed medication(s)/treatment(s):

_____

_____

_____
Director

10/06 2/18/15

11/20/2015