MIDLAND INNOVATION + TECHNOLOGY CHARTER SCHOOL

724-510-0944, FAX 724-660-4075

AUTHORIZATION for MEDICATIONS AND TREATMENTS

THE FOLLOWING IS TO BE COMPLETED BY THE PARENT/GUARDIAN:

Student's Name___________________________________DOB___________GRADE_____ SCHOOL YEAR___________

Physician's Name____Phone____________________________________

Physician's Address___________________________________Physician's Fax__________________________________

I give permission for the school nurse or designee to administer this medication and/or treatment as prescribed. I give permission for the school nurse to contact the child's physician as needed to further clarify the medication/treatment order. I release the **Midland Innovation + Technology Charter School** and its personnel from any liability for damages that our child could incur as a result of this request.

Student is permitted to carry and self-administer (please circle):

(Epi-pen, Rescue Inhaler, Insulin and Glucagon **ONLY**) : YES_____NO_____

ALL medications **must** be brought to the health office in the original container.

Parent/Guardian Signature____Date___________________________

Phone (H)________________________(Cell)______________________(e-mail)________________________________

THE FOLLOWING IS TO BE COMPLETED BY THE PHYSICIAN:

It is our procedure to request that medication be given before or after school hours whenever possible. If it is essential that the student receive the medication during school hours, please complete the following information:

Diagnosis for which medication/treatment is given:____

Name of medication(s)/treatment:____

Dose:_______________________Time to be given:____________________Length of Time:_________________

Significant side effects:____

Procedure to follow if an adverse reaction should occur:____

Student is permitted to self-carry and self-administer (please circle):

(Epi-pen, Rescue Inhaler, Insulin and Glucagon **ONLY**) : YES_____NO_____

Physician Signature:____Date:________________________