Tesseract School
*Engaging Minds. Inspiring Dreams.*

# HOMEOPATHIC TREATMENT PERMISSION FORM
(TO BE RENEWED ANNUALLY)

Student: ______________________________ Date of Birth: ______________________

Parent/Guardians: ________________________________________________

Teacher/Grade: ________________________________________________

## PHYSICIAN'S ORDER

I hereby request and authorize you administer to the above-named student:

| TREATMENT (1 per form) | DOSAGE | TIME | DURATION |
|---|---|---|---|
| | | | |

Diagnosis/Medical reason for treament: ________________________________________

Other medications/remedies this student is taking: ______________________________

Allergies: ________________________________________________

Possible side effects: ________________________________________________

Special Instructions: ________________________________________________

Print physician's name: ______________________________ Phone: ______________________

Physician's signature: ______________________________ Date: ______________________

## PARENT/GUARDIAN AUTHORIZATION

1. I request that the above treatment be given to my child during school hours as ordered by this student's physician.
2. I will immediately notify the school of any change in the treatment or remedy or physician's order, dosage change, frequency, or duration of administration. I will complete a new Permission Form for any such change.
3. I give permission for the school nurse to communicate with other school personnel about the action and side effects of the treatment or remedy.
4. I give permission for the school nurse to consult with this child's physician concerning any questions that arise with regard to the listed remedy or treatment, medical condition or side effects of this treatment or remedy.
5. **I agree to release The TesseracT School, and all school personnel, from any and all liability whatsoever arising out of or in connection with the administration of this homeopathic remedy or treatment as requested by the parent(s) and authorized by the student's physician or licensed health care provider, including any adverse effects to the remedy or treatment. I acknowledge that The TesseracT School and the school nurse have no way of verifying dosages or identifying possible side effects, and that this treatment or remedy is being administered based solely on the instruction and order of the parent/guardian and the students physician/health care provider. I have read the Medication Policy and assume the responsibilities as set forth.**

______________________________ Date: ______________________

(Parent/Guardian Signature)

6. Field trips:
   a) I give permission for a teacher/responsible adult to administer the treatment or remedy on a field trip, as necessary, following school procedure.
   b) I release all school personnel, the TesseracT School, and any responsible adult administering the treatment or remedy from any and all liability in the event of any adverse reaction resulting from the use or administration of this medication on a field trip or class outing.

______________________________ Date: ______________________

(Parent/Guardian Signature)