BUTLER AREA SCHOOL DISTRICT

AUTHORIZATION FOR PRESCRIPTION MEDICATION DURING SCHOOL HOURS

(Medication will not be given unless this form is completed and returned)

_____, _____, _____, may receive the following
(Student's Full Name) (Grade) (Room)
medication during school hours in order to maintain sufficient health to participate in the school program:

Name of Medication:_____

Prescribed Dosage: _____

Time Medication is to be taken: _____

Purpose of Medication: _____

Date Prescription Begins: _____ Ends: _____

Special Instructions, if any: (pills crushed; with water; etc.) _____

Possible side effects: _____

Procedure to be followed if reaction should occur: _____

Please choose one option concerning medication that is remaining at the end of the school year:

1. _____ I, the parent or my designee, will pick up the medication at the Nurse's Office before the end of the last day of school.

2. _____ You may discard the medication.

Any medication left after the end of the last day of school will be discarded by the nurse.

Physician Signature _____Date _____

Printed Name _____ Phone No. _____

I, the Parent/Guardian, do hereby release, discharge, and hold harmless the Butler Area School District, its agents and employees, from any and all liability, and claim whatsoever for the administration of the above medication to my child/ward should there develop an allergic or other reaction from the medication.

Parent/Guardian Signature _____ Date _____

Home Phone _____ Work Phone _____ Cell Phone _____

*Both Parental and Physician Authorizations must be signed before medication can be administered. Revised 9/98