**Authorization for Medication During School Hours**

 , , ,

*Student Full Name (Print)*

*Grade*

*Program & Session*

may receive the following medications 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: |   |
| 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. The nurse will discard any medication left after the end of

 the last day of school.

I, the Parent/Guardian, do hereby release, discharge, and hold harmless the Butler County Area Vocational-Technical School, 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.

I give permission for the fax transmittal of this form between Supplemental School Nurse and Physician Office.

|  |  |  |  |
| --- | --- | --- | --- |
| Parent/Guardian Signature: |   | Date: |   |
| Home Phone: |   | Work Phone: |   |

Both Parental and Physician Authorizations must be received before medication can be administered.

|  |  |  |  |
| --- | --- | --- | --- |
| Physician’s Signature: |   | Date: |   |
| Printed Name: |   | Phone Number: |   |