**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: | | |  |