BUTLER AREA SCHOOL DISTRICT
AUTHORIZATION FOR MEDICATION DURING SCHOOL HOURS

_____, _____, _____, may receive the following medication
(Student's Full Name) (Grade) (Room)

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. 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 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.

I give permission for the fax transmittal of this form between 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_____

BASD- (REVISED 1-18)