

BETHANY COMMUNITY SCHOOL

Division of Student Services

PERMISSION TO ADMINISTER MEDICATION- *Prescription and Non-prescription*

This form gives permission to authorized members at your child's school, to administer medication to your child. This permission form is valid for the 2024-2025 school year only.

Student's Name _____ Age _____ Grade _____

School Name _____ Teacher _____

Prescription Medication:

This section must be completed and signed by both the parent and the child's physician for prescription medication. The medication must be in a prescription bottle with the original label attached.

Physician's Name _____ Phone _____

Physician's Fax# _____

Medication Prescribed _____ Dosage _____

Time(s) to be given at school _____

Purpose of medication _____

Possible side effects _____

Physician's Signature _____ Date _____

I hereby release the Bethany Community School Board of Directors, their agents, and employees from any and all liability that may result from my child taking this medication.

Parent's Signature _____ Date _____

This permission form and a log of the prescription medication administered to your child indicating the date, time given, and the initial of the authorized staff member administering the medication will be kept on file at the school. If your child's medication or physician changes during the school year, a new permission form must be completed.

Non-prescription medication:

This section must be completed and signed by the parent for non-prescription medication such as Ibuprofen, Acetaminophen, or Advil. Please provide the medicine for your child.

Medication _____ Dosage _____

Time(s) to be given at school _____

Purpose of medication _____

I hereby release the Bethany Community School Board of Directors, their agents, and employees from any and all liability that may result from my child taking this medication.

Parent's Signature _____ Date _____

Physician's Signature _____ Date _____