Bethel Public Schools

PARENTAL AUTHORIZATION TO ADMINISTER MEDICINE(S)

If you would like for the school to dispense medicine to your child, please complete, sign and turn this form into the site office.

<u>This form must be completed and returned each year.</u>

Student Name:_____ **Grade/Teacher:**_____

I hereby give my consent and authorize the school secretaries or school principal to:

☐ Administer _____, a **non-prescription (Tylenol, Ibuprofen, Midol, etc.)** medication which I am supplying the school office. Non-prescription medication will be given per bottle instructions. **All medication shall be turned in to the school office in a new unopened bottle.**

☐ Administer _____, a **filled prescription** medication I am supplying the school office. Dosage and time will be followed on the prescription label or physician's written instructions. **All medications shall be turned in to the school office in a properly labeled, unexpired prescription bottle. Bottles with expired labels will not be accepted.**

☐ Permit the student to retain an Epi-Pen or inhaler on the student's person since the medication must be administered at unpredictable intervals throughout the day. **A physician's statement that the student is capable of, and has been instructed in the proper method of, self-administration of medication is attached.**

Otherwise Med. will remain in the office.

I understand that under state law, the Board of Education, the School District or employees of the District shall not be liable to the student, and/or student's parent or guardian for civil damages for any personal injuries to the student which shall result from administering the medications I have hereby authorized.

_____ _____

Parent or Guardian Name (Please print name) Phone Number

_____

Parent or Guardian Signature

_____ _____

Witness Signature Date

Time to be administered _____