

# **BETHANY COMMUNITY SCHOOL**

Division of Student Services

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## **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 2026-2027 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.

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### **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** \_\_\_\_\_