BUTLER ACADEMY

Authorization for Prescription Medication at School

MUST BE SIGNED BY GUARDIAN & PHYSICIAN

PLEASE PRINT

SCHOOL YEAR _____

STUDENT'S NAME

BIRTHDAY

LEGAL GUARDIAN

DAYTIME PHONE#

NAME OF MEDICATION

DIAGNOSIS FOR MEDICATION AT SCHOOL

DOSAGE/ROUTE AT SCHOOL

DATE TO START MEDICATION

DATE TO STOP MEDICATION

TIME OF DAY MEDICATION IS TO BE GIVEN AT SCHOOL

EXPIRATION DATE OF MEDICATION

POSSIBLE SIDE EFFECTS

PRINT PHYSICIAN NAME

PHYSICIAN SIGNATURE

DATE

PHYSICIAN PHONE #

Parents Please Read Carefully

I understand that all medication will be provided by the parent or guardian in the original container, clearly labeled with the child's name. I will notify the school if the medication is discontinued or the dosage has been changed. If the dosage has been changed, please obtain a new Physician's Order. Permission is granted to the principal and/or the school nurse to share this information with individuals who have responsibility for my child. The first dose will be given at home so that I can monitor adverse reactions. I give the school nurse my permission to contact the above-named Physician's Office to request medical information concerning my child. I am responsible for replacing medication before the expiration date.

PARENT/GUARDIAN SIGNATURE

DATE