BUTLER ACADEMY

Authorization for Non-Prescription Medication at School

(SIGNED BY PARENT ONLY)

School Year:_____

Student's Name:_____ Date of Birth:_____

Legal Guardian Name:_____ Daytime Phone#:_____

Name of Medication:_____

Dosage/Route at school: _____

Time for Medication to be given: _____

Reason for Medication:_____

Date to Start Medication:_____ Date to Stop Medication:_____

Expiration Date of Medication:_____

PHYSICIAN NAME: _____

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 of medication changes, I will obtain a new Physician order.** Permission is granted to the school official and/or 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.

Please acknowledge the following statements by checking the boxes below:

- ❑ A SEPARATE PERMISSION FORM IS REQUIRED FOR EACH MEDICATION TO BE GIVEN.
- ❑ PARENTS ARE RESPONSIBLE FOR NOTING THE EXPIRATION DATE OF ALL MEDICATION. EXPIRED MEDICATION WILL NOT BE GIVEN AT SCHOOL.
- ❑ ANY MEDICATION NOT PICKED UP BY THE LAST DAY OF SCHOOL WILL BE DESTROYED ACCORDING TO SCHOOL DISTRICT GUIDELINES.
- ❑ ANY OVER-THE-COUNTER MEDICATION GIVEN EVERY DAY FOR 10 CONSECUTIVE DAYS MUST HAVE PHYSICIAN'S AUTHORIZATION.

Legal Guardian Signature:_____ Date:_____