BUTLERACADEMY

Authorization for Prescription Medication at School

(MUST BE SIGNED BY PARENT AND PHYSICIAN)

School Year:_____

Student's Name:_____ Date of Birth:_____

Legal Guardian Name:_____ Daytime Phone#:_____

Name of Medication:_____

Diagnosis for medication at school:_____

Dosage/Route at school_____

Time of Day Medication is to be given at school._____

Date to start medication:_____ Date to Stop Medication:_____

Expiration Date of Medication:_____

Possible Side Effects:_____

Can student self medicate? YES or NO (Circle One)

PHYSICIAN NAME: _____ Date:_____

PHYSICIAN SIGNATURE:_____

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.

Legal Guardian Signature:_____Date:_____

_____ _____

BA NURSE SIGNATURE *DATE*