ARCANUM BUTLER LOCAL SCHOOLS
School Health Services

SCHOOL MEDICATION PERMISSION AND INSTRUCTION

PARENT/GUARDIAN PERMISSION Date: _____

Student's Name _____ Birthdate _____

Address _____ City _____

School _____

Grade _____ Teacher _____

I hearby request and grant permission for the above named school to supervise the medication routine below prescribed for the above-named child.

We/I hereby release the designated medication administrator, the above named school system and school board, the Principal of school of which said child is the student, any supervisory personnel, their heirs, executors, administrators, or successors, from any and all liability that may arise out of services rendered in dispensing the below named medication.

I further agree to submit a revised statement by the physician who prescribes this drug, if any of the information below changes.

_____
Parent/Guardian signature

OVER THE COUNTER/NON-PRESCRIPTION DRUGS
MEDICATIONS MUST BE IN ORIGINAL MEDICATION CONTAINER

Medication (name, dosage, route) _____

Reason for use: _____

Date to begin: _____ Date to cease: _____

Time or intervals dosage of drug is administered: _____

Special instructions and/or adverse affects: _____

_____ _____
Parent/Guardian signature

PRESCRIPTION DRUGS – PHYSICIAN'S DIRECTIONS
MEDICATIONS MUST BE IN ORIGINAL MEDICATION CONTAINER

Medication (name, dosage, route) _____

Reason for use: _____

Date to begin: _____ Date to cease: _____

Time or intervals dosage of drug is administered: _____

Special instructions (including sterile conditions and storage): _____

Adverse effects to report (if any): _____

Telephone number(s) at which physician can be reached in emergency: _____

**Dr. requests teacher's comments _____NO – teacher comments are not necessary

_____YES – Please observe the following: _____

_____
Physician's signature

I request that the above medication be administered to my child according to the instructions provided. I agree to deliver the medicine to the school in the container in which it was dispersed by the prescribing physician or licensed pharmacist. **I grant permission for the school nurse to confer with the above licensed prescriber regarding my child's health and treatment issues as they pertain to the above medication /diagnosis and his/her educational and behavioral management needs.** If the above information changes, I will submit a revised statement signed by the physician.