Butler Tech

AUTHORIZATION FOR NONPRESCRIBED MEDICATION OR TREATMENT

To the Parent:

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO POSSESS OR USE NONPRESCRIBED MEDICATIONS IN SCHOOL. ALL SPACES MUST BE COMPLETED.

________________________________ ________________________________
Name of Student Telephone number of Parent / Guardian

____
Address

________________________________ ________________________________
Building Date of Birth

____
Parent / Guardian Email

A. I am requesting permission for my child named above to: (Check one or both)

[ ] use or receive the following over-the-counter medication(s).

Medication: ____

Dosage: ____

Check Option 1 or 2 below.

[ ] self-administer such medication(s) in the presence of an authorized staff member.

[ ] keep the medication(s) in his/her possession and self-administer the medication(s) as needed.

B. I will assume responsibility for safe delivery of the medication to school.

C. I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment.

D. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

____________________________________ ________________________
Signature of Parent Date

____________________________________ ________________________
Home Telephone Work Telephone

LICENSED PRESCRIBER'S STATEMENT

To the Prescriber:

Butler Tech requires that all of the following information be provided before it will administer medication or treatment to the student named on this form.

Student's Name: ____

I have prescribed the following medication: ______________________________

____

____

Medication is to begin on (beginning date): ____________ be taken at: ____________ and

end on (ending date): ____________

Dosage, instructions, or precautions (including possible side effects): ____________________

____

____

____

This student is both capable and responsible to self-administer this medication:

_______ With Supervision _______ Without Supervision

I have prescribed the following treatment for this student:

____

____

____

____

____

____

Beginning Date: ____________________ Ending Date: ____________________

For student with diabetes only:

_____ I authorize the student to attend to his/her diabetes care and management, in accordance with my order, during regular school hours and school sponsored activities. I have determined that the student is capable of performing diabetes care tasks.

_____ I do not authorize the student to attend to his/her diabetes care and management during regular school hours and school sponsored activities.

Prescriber's Signature: ____________________ Telephone: ____________________

Printed/Typed Name: ____________________ Date: ____________________

AUTHORIZATION FOR STAFF

The following staff members are authorized to administer the above-nonprescribed medication(s)/treatment(s):

____

____

____

Principal