Butler Tech

AUTHORIZATION FOR PRESCRIBED MEDICATION/DRUG OR TREATMENT

To the Parent:

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO POSSESS OR USE PRESCRIBED MEDICATIONS OR TO RECEIVE TREATMENT 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 all that apply)

_____ use or receive prescribed medication in accordance with a doctor's prescription

_____ self-administer prescribed medication in my presence or that of an authorized staff member

_____ self-administer Epi-Pen (5330 F4) or inhaler in accordance with a doctor's prescription

_____ for student with diabetes only: self-administer diabetes care in accordance with Policy 5336

B. I will assume responsibility for safe delivery of the medication/drug to school, except for diabetes medication student is permitted to posses pursuant to Policy 5336.

C. I will notify the school immediately if there is any change in the use of the medication/drug or the prescribed treatment, or if I wish to revoke this authorization.

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

Signature of Parent / Guardian _____ Date _____

Primary Telephone Number _____ Work or Cell Number _____

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:

_____

_____

_____

_____

_____

_____

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-prescribed medication(s)/treatment(s):

_____

_____

_____
Principal