BETHANY COMMUNITY SCHOOL

Division of Student Services

PERMISSION TO ADMINISTER MEDICATION- *Prescription and Non-prescription*

This form gives permission to authorized members at your child's school, to administer medication to your child. This permission form is valid for the 2021-2022 school year only.

Student's Name__________________________________ Age ________ Grade ______________________

School Name ____ Teacher _______________________

Prescription Medication:

This section must be completed and signed by both the parent and the child's physician for prescription medication. The medication must be in a prescription bottle with the original label attached.

Physician's Name ____ Phone ________________________

Physician's Fax# __________________________

Medication Prescribed _______________________________________ Dosage ________________________

Time(s) to be given at school ____

Purpose of medication ____

Possible side effects ____

Physician's Signature ____ Date _____________________

I hereby release the Bethany Community School Board of Directors, their agents, and employees from any and all liability that may result from my child taking this medication.

Parent's Signature ____ Date _____________________

This permission form and a log of the prescription medication administered to your child indicating the date, time given, and the initial of the authorized staff member administering the medication will be kept on file at the school. If your child's medication or physician changes during the school year, a new permission form must be completed.

Non-prescription medication:

This section must be completed and signed by the parent for non-prescription medication such as Ibuprofen, Acetaminophen, or Advil. Please provide the medicine for your child.

Medication ____ Dosage _________________________

Time(s) to be given at school ____

Purpose of medication ____

I hereby release the Bethany Community School Board of Directors, their agents, and employees from any and all liability that may result from my child taking this medication.

Parent's Signature ____ Date ______________________

Physician's Signature ____ Date ____________________