VANDALIA-BUTLER CITY SCHOOLS

AUTHORIZATION FOR MEDICATIONS TO BE TAKEN DURING SCHOOL HOURS

PART I The following section is to be completed by the **PARENT**:

School _____ Student's Name _____ Date of Birth _____ Gender _____

Physician's Name _____ Address _____ Phone _____

I request my child be assisted in taking the medicine(s) described below at school by authorized persons or permitted to medicate herself/himself as also authorized by me and my physician (see below).

Further, we (I) understand school personnel are not legally obligated to administer oral medication to any child and, therefore, we (I) agree to hold the school district and its employees free from any and all responsibility for the results of such medication or the manner in which it is administered and identify each of them against loss by reason of any civil judgment.

Parent/Guardian Signature _____ Date _____ Home Phone _____ Emergency Phone _____

Medication must be received in the container in which it was purchased or dispensed by the prescribing physician or licensed pharmacist. Oral medication, for release, refers to medication in pill or liquid medication that must be in pre-measured containers. All others cannot be administered. As necessary, an epinephrine autoinjector can be used to treat anaphylaxis caused by life-threatening allergic reactions caused by insect bites or stings, foods, medications, latex, and other causes. The schools will not assume the responsibility for administering injections or changing dressings. The only exception to this area is for those students with an allergy to bee sting in which case the use of Epi-pen auto injection or other pre-measured medications may be administered.

PART II **PHYSICIAN** please complete for ***any*** medication (prescription or over-the counter) to be taken during school hours.
Diagnosis for which medication is given: _____

Name or Medication:
Form of Medication (Please Check) ___ Inhaler ___ Spray ___ Pill ___Liquid ___Ointment
Dose:
Time to administer:
If medication is to be given "AS NEEDED", describe:
How often can it be repeated?
Is child authorized to take medication by herself/himself? ___ YES ___ NO
List significant side effects:
Length of time this treatment is recommended:
Other information/special instructions: _____

Physician's Signature _____ Date _____

Address _____ Emergency Phone Number _____