Byng Schools

School Nurse

Parental Authorization To Administer Medications

Name of Student:_____ **Grade:**_____

Byng Public Schools encourages parents to give medication at home and on a schedule other than during school hours. This form **must be completed** and is only good for the **current** school year. **Parents must provide all medications in original container except those listed below. Medication sent without written parent permission will not be given.** Complete a new form for each medication or for changes.

Prescription Medication **Must be in Original Container**

Medication:_____ Reason:_____
Dosage:_____ Time(s) to be given:_____
Dates to administer: From____/____/_____ To _____/_____/_____
Do Not give if: _____
If medication is PRN (as needed) Reason to give: _____
How often:_____

Over-The-Counter Medication **To Be Completed and Provided By Parent/Guardian**

Fill out and return to School Nurse with a **NEW (unopened) Container** of age appropriate medication.

Medication:_____ Dosage:_____
Purpose:_____ Time(s) to be given:_____
Dates to be given:_____ Allergies:_____
Instructions:_____

Over-the-Counter-Medications available at school
For the treatment of minor injuries or discomfort, **only** the following over the counter medications ***are available*** for use with parent permission: **cough drops, antibiotic ointment, aloe vera gel, anti-itch cream/lotion and hydrocortisone cream.**
If you do not wish for your child to receive any of the above over the counter medication, Please list:_____

To Be Completed by Parent/Guardian

I understand that all medication must be in the **original** container with label intact. If medication is not properly labeled, it will not be given. I give permission for the school nurse or principal's designated school employee to administer the above medication(s) according to Byng School Policy. I understand that under state law, the board of education, the school district, or the employee of the district shall not be liable to the student which results from the act of omissions in administering the medicine I hereby authorized or from the self-administration of medication by the student. I also understand that any medication not picked up by the parent by the end of the school year will be destroyed according to FDA Guidelines.

I have provided the most current and accurate Health information for my child. I understand that any health information that is pertinent for the safety and education of my child may be shared with school personnel who have the need to know. Health information is considered confidential. My child may receive the above over the counter medication, unless otherwise listed.

_____ _____ _____
Signature of Parent/Guardian **Date** **Phone**