

**BEAUFORT COUNTY SCHOOLS
AUTHORIZATION FOR MEDICATION DURING SCHOOL HOURS**

Student's Name: _____ School: _____

Medication: _____ Dose: _____ Route: _____

Time(s) medication is to be given: AM _____ PM _____

Date Medication is to be administered: FROM: _____ TO: _____

If medication is ordered **as needed** please indicate specific circumstances when medication should be given: _____

Significant Information (side effects, toxic reactions, omission reactions)

Contraindications for Administration: _____

Insulin, Inhaler, EpiPen

Child **May NOT** self Medicate: (Y/N) _____ Child **MAY** Self Medicate (Y/N) _____

PHYSICIAN'S SIGNATURE

DATE

PHONE #

STUDENT CONTRACT FOR SELF-CARRIED MEDICATION

I plan to keep: INHALER, INSULIN, EPIPEN (state where) _____

I agree to use: INHALER, INSULIN, EPIPEN, MEDS as prescribed.

I will not allow others to use INHALER, INSULIN, EPIPEN, MED.

I will notify school staff if I am having more difficulty than usual with my health condition.

STUDENT SIGNATURE

DATE

This medication will be furnished by parent/guardian in a container properly labeled by a pharmacist, and over the counter medicine must be in the original container. All medications must have child's name, medication dispensed, dose prescribed and time it is to be given. I hereby give my permission for my child to receive medication during school hours. This medication has been prescribed by a licensed physician. I hereby release the School Board and their agents and employees from all liability that may result from my child taking the prescribed medication.

PARENT/GUARDIAN'S SIGNATURE

DATE

PHONE

SCHOOL USE

Name and title of person to administer medication _____

Review by School Nurse _____ Date _____

Approved by Principal _____ Date _____