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 #

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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 pharmacists, 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
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SCHOOL USE
Name and title of person to administer medication____
Review by School Nurse ________________________________Date __________________________
Approved by Principal __________________________________Date __________________________