BATH COUNTY SCHOOLS

AUTHORIZATION TO ADMINISTER PRESCRIBED MEDICATION

STUDENT _____ Birthdate _____

School _____ Grade _____ School Year _____

Parent/Guardian 1: _____ **Parent/Guardian 2:** _____

Daytime Phone (____) _____ Daytime Phone (____) _____

Cell (____) _____ _____

Authorization expires at the end of the school year

PARENTAL MEDICATION CONSENT:

I give permission for my son/daughter to receive the prescribed medication listed below. I also give permission for an exchange of information between school district personnel and the health care provider, if necessary, regarding this medication. I agree to notify the school in writing at the withdrawal of this request or when a change in this medication occurs.

I understand that it is my responsibility to:

- Transport the medication to school in a ***pharmacy-labeled*** container
- Replace the supply of medication when needed
- Pick up medication or direct staff to discard remaining medication upon discontinuation or at the end of the school year

Parent / Guardian Signature _____ Date _____

HEALTH CARE PROVIDER'S ORDER FOR MEDICATION TO BE GIVEN AT SCHOOL

Medical Condition:		
Name of Medication: (generic and trade)		
Dosage of Medication:	_____ mg / cc / tsp / puffs	**Form:** ☐ Tablet/Capsule ☐ Liquid ☐ Inhaler ☐ Nebulizer ☐ Other _____
Route:	☐ Oral ☐ Eyes ☐ Ear ☐ Nose ☐ Topical ☐ Rectal ☐ Other _____	
Administration Time:	☐ **Daily** at _____ ☐ **As needed** - Describe frequency & symptoms for which medication should be given: _____ ☐ May be repeated in _____ (time) minutes / hours	
Possible Side Effects:		
For inhaled asthma medication ONLY:	☐ In my professional opinion, this student should be allowed to carry and use this medication by him/herself. ☐ In my professional opinion, this student ***SHOULD NOT*** carry this medication by him/herself.	

Health Care Provider's Name (Please print) _____ Phone (____) _____

Health Care Provider's Signature _____ Date _____