Administering Medication	JGCD-E(1)	REVISED MAY 21, 2001

Request for Medication to be given during School Hours

To be completed by physician for prescription drugs;

Name of Student_____School_____

Medication_____Dosage_____

*****No injection will be given except in extreme emergency, such as allergy to bee or wasp stings.*

Times(s) medication is to be given: a.m._____p.m._____

To be given from (date)_____to_____

Significant Information: (include side effects, toxic reactions, and omission reactions):
_____, _____, _____

If an emergency situation occurs during the school day or if the student becomes ill, school officials are to:

A. Contact me at my office_____Tel.Number_____
B. Call 911 or take child immediately to the emergency room at _____
C. Other options_____

This medication will be furnished by parent or guardian within a container properly labeled by a pharmacist with identifying information, (e.g., name of child, medication dispensed, dosage prescribed, and the time it is to be given.)

_____ _____
Physician's Signature **Date**

Parent's Permission

I hereby give my permission for my child (named above) to receive Medication during school hours. I understand that the school undertakes no responsibility for the administration of medication. A licensed physician has prescribed this medication. I hereby release the Anson County Board of Education and its agents and employees from any and all liability that may result from my child taking the prescribed medication.

_____ _____ _____
Signature of Parent or Guardian **Date** **Telephone Number**

(School Use Only)
Name and Title of person to administer Medication_____

Approved by_____
Principal's Signature
Reviewed By_____
School Nurse's Signature

Anson County Schools