

Request for Medication to be given during School Hours

To be completed by parent for over-the-counter 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 worksite/home _____ 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 with the original container properly labeled by the parent with identifying information, (e.g., name of child medication dispensed, dosage prescribed, and the time it is to be given.)

Parent'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. 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

