

CHARLES A. BEARD MEMORIAL SCHOOL CORPORATION

REQUEST AND AUTHORIZATION TO ADMINISTER OVER THE COUNTER MEDICATION
2022-2023 SCHOOL YEAR
All spaces must be completed before medication will be administered at school. This is a two-page form.

TO BE COMPLETED BY PARENT/GUARDIAN

BUS #
STUDENTS NAME: GRADE/TEACHER:
ADDRESS:
MEDICATION: DOSAGE & ROUTE:
TIME TO BE GIVEN AT SCHOOL: HOW MANY:
QUANTITY OF MEDICATION SENT TO SCHOOL (number of tablets in bottle):
PURPOSE FOR MEDICATION:
DATE MEDICATION IS TO BE DISCONTINUED:

PLEASE LIST ALL MEDS THAT YOUR CHILD IS CURRENTLY TAKING:

- 1.) 2.)
3.) 4.)

HEALTH INFORMATION: Please list your child's health problems, chronic conditions, or medications that the school should be aware of in caring for your child.

- 1.)
2.)

NO MEDICATION WILL BE SENT HOME WITH A STUDENT. (Please list a parent or guardian to whom a medication may be released:

Name: phone #

I understand that the School Nurse or other designated employee(s) is authorized to administer medication to my child.

BY SIGNING THIS FORM, I AGREE TO ALLOW THIS INFORMATION TO BE SHARED WITH ANY AND ALL SCHOOL PERSONNEL WHO MAY BE IN CONTACT WITH MY CHILD.

PARENT/GUARDIAN SIGNATURE: DATE:

PARENT/GUARDIAN HOME/CELL #

- ALL MORNING MEDICATION NEEDS TO BE GIVEN AT HOME
NO OVER THE COUNTER MEDS WILL BE GIVEN BEFORE NOON
ALL MEDICATION MUST BE IN THE ORIGINAL CONTAINER
PARENTS RESPONSIBILITY TO MONITOR WHEN THE CHILD'S MEDICATION NEEDS TO BE REFILLED AND RESTOCK THE SUPPLY AT SCHOOL

****PLEASE RETURN THIS COMPLETED FORM ALONG WITH YOUR CHILD'S MEDICATION TO THE NURSE'S OR PRINCIPAL'S OFFICE****
UPDATED 4/17