BEAUFORT COUNTY SCHOOLS
REQUEST TO ADMINISTER MEDICATION

Students Name:_____ DOB:_____School:_____

Medication_____Dose_____Route_____

Time(s) medication to be given: **AM**_____**PM**_____

Date medication 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/ Epi-pen Use:
Can child self-medicate? (Yes / No) please circle which applies

_____ _____
Print Physician Name Name of Office

PHYSICIAN'S SIGNATURE (Required) DATE PHONE NUMBER

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 my **INHALER, INSULIN, EPIPEN, MEDS**
I **will** notify school staff if I am having more difficulty than usual with my health condition.

_____
STUDENT SIGNATURE **DATE**

Note: Medication must be furnished by parent/guardian in a container properly labeled by a pharmacist, 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 request designated school personnel to administer or oversee the administration of the medication(s) as prescribed by the above prescriber. I certify that I have legal authority to consent to medical treatment for the student named above. I authorize the school nurse to communicate with the medical care provider.

_____
PARENT/GUARDIAN SIGNATURE (Required) DATE PHONE NUMBER

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SCHOOL USE ONLY
Reviewed by **School Nurse**_____**DATE**_____

REVISED *07/16*