

Bertie County Schools Medication Consent Form

School Year: _____

Student: _____ DOB: _____ School: _____
Parents: _____ Phone: _____ Grade/Teacher: _____

To be completed by Health Care Provider:

In order to keep this student in optimum health and to help maintain school performance, it is **necessary** that this medication be given during school hours by school personnel.

Medication: _____ Dosage: _____
Route: _____ Time: _____

If medication is ordered **as needed**, please indicate specific circumstances when medication should be given. _____

Significant information: possible side effects: _____

Contraindications for administration: _____

For students with asthma, diabetes and/or those subject to anaphylactic reactions, the following permission is given for **inhalers, insulin or epinephrine auto-injectors**.

☐ _____ has been instructed, has demonstrated and understands the proper use of his/her emergency medication & he/she should be allowed to self-administer.

☐ _____ should not be allowed to self-administer his/her medication.

Physician/Provider Signature

Date

Phone Number

To be completed by Parent/Guardian:

I hereby give permission for _____ to receive _____
(Student's Name) (Name of Medication)
during school hours. Medications will be sent in the original container.

Please list any side effects and/or special instructions (i.e. difficulty swallowing, etc.)

I hereby release the Bertie County School Board, their agents and employees from all liability that may result from my child taking this medication. My signature indicates that I have read and understand the Bertie County Schools In-School Medication Policy and Procedure.

Parent/Guardian Signature

Date

Reviewed by School Nurse: _____ **Date:** _____

Please Note: Medications will not be kept over the summer and will be properly disposed of 7 calendar days following the last day of school if not picked up.