

BALDWIN COUNTY SCHOOL HEALTH PROGRAM REQUEST FOR ADMINISTRATION OF MEDICATION

Permission is hereby granted to the school nurse and the local school principal or his/her designee to administer and/or supervise my child in taking the following prescribed medication.

I hereby release and discharge the school nurse and the Board of Education and it's employees and officials from any and all liability in case of accident, injury, damage or any other mishap in connection with the administration and supervision of taking said medication including side effects, illness, or other injury which might occur to my child. I hereby release aforementioned officials from any liability because of any injury or damage, which might occur.

I give the above-mentioned personnel permission to contact my child's health care provider and/or pharmacist to acquire medical information concerning my child's diagnosis, medication, and other treatment(s) required.

I understand that:

Medications prescribed and non-prescribed, must be in the original container.

The Parent/Guardian must provide specific instructions (including drugs and related equipment) to the school nurse, principal or his/her designee.

It will be the responsibility of the parent/guardian to inform the school of any changes in pertinent data. New medications prescribed and non-prescribed, will not be given unless a new form is completed.

Prescribed and non-prescribed medication will be taken directly to the school clinic or office. Students may not have medication in their possession, except if a child requires and inhaler for the treatment of asthma.

Students who violate these rules will be in violation of the Alcohol/Illegal Drug Use Policy (JCDAC).

A daily record shall be kept on each prescribed and non-prescribed medication administered. This record will include the student's name, date, medication administered, time and signature of school personnel who supervised.

NAME OF STUDENT _____ BIRTHDATE _____

SCHOOL _____ GRADE _____ TEACHER _____

MEDICATION _____ DATE OF PRESCRIPTION _____

DOSAGE & TIME OF ADMINISTRATION _____

ALLERGIES _____ STOP MEDICATION ON _____

INSURANCE: BC/BS _____ MEDICAID _____ STATE MERIT _____ PEACHCARE _____ OTHER _____.

STATEMENT OF PARENT OR GUARDIAN

I HEREBY GIVE PERMISSION FOR MY CHILD TO RECEIVE MEDICATION AT SCHOOL AS PRESCRIBED BY MY CHILD'S PHYSICIAN.

SIGNATURE OF PARENT/GUARDIAN _____ DATE _____

HOME PHONE _____ WORK PHONE _____ BEEPER/CELL _____
