BEAR GRASS CHARTER SCHOOL
AUTHORIZATION FOR MEDICATION DURING SCHOOL HOURS

Students Name _____

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**

Medication will 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 hereby give my permission for my child to receive medication during school hours. This medication has been prescribed by a licensed physician. I hereby release the School Board and their agents and employees, from all liability that may result from my child taking the prescribed medication. I give permission for the School Nurse to communicate with the Medical Provider concerning diagnosed medical condition related to above prescribed medication.

_____

PARENT/GUARDIAN SIGNATURE(Required) DATE

PHONE NUMBER _____

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SCHOOL USE ONLY

Reviewed by School Designee

Signature_____DATE_____