CHARLES A. BEARD MEMORIAL SCHOOL CORPORATION

REQUEST AND AUTHORIZATION TO ADMINISTER OVER THE COUNTER MEDICATION

2017-2018 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