Bath County Public Schools

AUTHORIZATION/PARENT CONSENT FOR ADMINISTERING MEDICATION

(USE A SEPARATE FORM FOR EACH MEDICATION)

Student's Name: _____ Grade: _____
First Middle Last

Date of Birth: ____/____/____ Allergies: _____
Month Day Year

Parental Consent for Prescription or Over-the-Counter Medications

I am the Parent or Guardian of _____. I give my permission for him/her to take the following medication while in school. I hereby acknowledge that I have read and understood the School Board Regulations relating to the taking of medications. I hereby release the Bath County Public Schools and its employees from any claims or liabilities connected with its reliance on this permission and agree to indemnify, defend and hold them harmless from any claim or liability connected with such reliance. I authorize a representative of the school to share information regarding this medication with the licensed prescriber listed below.

_____ _____ _____
Parent/Guardian Signature Daytime Phone Date

Over-the-Counter Medication Authorization ONLY

OTC Medication _____ Dosage/Time(s) Given _____

Reason _____ Possible Side Effects _____

Allergies _____ Other Instructions _____

Physician's Name _____ Telephone # _____

Prescription Medication Authorization

(For Use by Licensed Prescriber ONLY)

Diagnosis _____ Medication _____

Dates medication must be administered at school _____

_____

Dosage (amount) _____ Time(s) of Day _____

A. Serious reactions can occur if the medication is not given as prescribed: _____Yes _____No
If yes, describe:

B. Serious reactions/adverse side effects from this medication may occur: _____Yes _____No
If yes, describe:

Action/Treatment for reactions: _____

SEVERE ALLERGIC REACTIONS THAT REQUIRE AN EPI-PEN / ASTHMATICS / DIABETICS ONLY:

This student is responsible for self-administering this medication?

_____YES (supervised) _____YES (unsupervised) _____NO This student may carry this medication. _____YES _____NO

Licensed Prescriber's Name (please print)_____

Phone No _____ Emergency No _____

Licensed Prescriber's Signature _____ Date _____