BERKELEY COUNTY SCHOOL DISTRICT

PARENT'S REQUEST FOR GIVING MEDICINE AT SCHOOL

Student: _____ Date of Birth: _____ Student ID No. _____

School: _____ Grade: _____ Teacher: _____

I request my child receive the medication _____

prescribed by _____ for the period from _____ to _____

Amount (Dosage) _____ and time(s) to be given _____

This medication is being given for _____

List any potential reactions with appropriate treatment: _____

I understand the medicine is to be furnished by me in the original container, labeled with the name of the medicine, the dosage to be given, time(s) of day to be taken, and the expected duration of treatment. I further understand it is my responsibility to deliver and pick up medicines and to furnish the school another form if any changes are made in this medication. The physician's name must be on the label if it is a prescription medication.

Signature of Parent / Guardian Date Signature of Physician Prescribing Medication Date

I will not hold the school, school district, or school personnel liable for any adverse drug reaction when the medicine is administered according to prescribed methods.

Parent/Guardian Signature _____ Date _____

SELF-ADMINISTRATION OF MEDICATION - Self-administration of controlled substances will not be permitted.

Physician must initial each item and sign below in order for student to be allowed to self-medicate at school.

The student named above:

(a) has been instructed regarding the appropriate use of the medication noted above (e.g., indications, actions, side effects, when to take the medication, when not to take the medication, when to seek assistance). _____

(b) has demonstrated competency for safely self-administering the medication noted above. _____

I agree that the student named above should be allowed to self-administer the medication(s) noted above while in the classroom and in any area of the school or school grounds, at any school-sponsored activity, in transit to and from school or school-sponsored activities, and during before-school or after-school activities on school –operated property.

Prescribing Health Care Provider's Signature Date Provider's Printed Name Office Phone No.

Parent/Guardian must initial each item and sign below in order for student to be allowed to self-medicate at school.

(a) I request my child be allowed to self-administer the medication noted above as prescribed while in the school setting. _____

(b) My child has been instructed about the proper use of the medication noted above. _____

(c) My child has shown me that he/she can safely self-administer the medication noted above. _____

(d) My child and I will be responsible for the proper use and safe-keeping of the medication. _____

(e) I will not hold the school district or any of its employees or agents liable if an injury occurs related to my child's self-medicating. I will be responsible for any costs related to any claims that occur related to my child self-medicating. _____

(f) I understand that my child will lose the privilege to self-medicate if he/she endangers himself or another student by misusing the medication. _____

(g) I understand that my child may only self-administer the medication noted above. All other medications must be given to my child by a school employee. _____

Parent/Guardian Signature: Date: