# Bedford County Public Schools

## Physician/Parent Authorization To Administer Medication

Permission to fax to medical office/ school/parent

Dear Parent or Guardian:

In order for Bedford County Public Schools to assist with administration of medication for your child during the school hours the following guidelines need to be followed:

- The physician needs to fill out this form for any prescription medication given. The name of the medication, dosage, route, purpose, side effects and time interval of medication to be taken must be included.
- This form needs to be updated as indicated if medication changes occur throughout the school year.
- The parent or guardian must sign this form requesting that the school district comply with the physicians order.
- Medication must be brought to school by the parent or guardian in a container appropriately labeled.
- The school must have a separate authorization form for each medication requested.

Name of Student_____Grade_____

School_____Teacher_____

Medication_____Dosage_____

Purpose of Medication/Diagnosis_____

Time of day medication is to be given_____Route_____

Possible Side Effects_____

Allergies_____Discontinue Date_____

_____ _____ _____

**Date** **Physician Signature** **Physician Printed Name**

I hereby give permission for my child_____to take the above medication at school as ordered. I understand that it is my responsibility to furnish this medication.

_____ _____

**Date** **Signature of Parent/Guardian**

**Self-administration is determined by the Physician and applies to Inhaler, Insulin or Auto-Injectable Epinephrine for any student.**

The following student_____has knowledge of this medication and has demonstrated the capability of self-administering this medicine. **Physician Must Circle Below**

**Inhaler** **Auto-Inject Epinephrine** **Insulin**