

Note to Parent/Guardians:

To comply with State Law governing the administration of medication at school, the Pendleton County School system requires that all students who need medication during school hours do the following:

1. The parent or legal guardian must sign the written consent form for both non-prescription and prescription medication. *(The school does not provide non-prescription medication, such as Tylenol, Benadryl, etc. It is the parent's responsibility to send this medication to the school in the original container.)*
2. The Prescription medication section of this form must be signed by the physician, and the prescription medication sent to school in the original prescription bottle.
3. A medication form is required for each medication.
4. If there is any question about the dosage of medication the child is to receive, it will not be given unless the parent or physician clarifies instructions.
5. The first dose of any medication must be given at home due to the possibility of allergic reaction.
6. Medication should only be taken at school when absolutely necessary; it is best to give medications at home.

Name of Student _____ Date of Birth _____
Age _____ Grade _____ School _____

TO BE COMPLETED BY PARENT/GUARDIAN

I, _____ hereby request that trained, authorized staff of the Pendleton County Board of Education administer the non-prescription medication listed below to my son/daughter as directed by the physician.

PARENT/GUARDIAN SIGNATURE

TELEPHONE

DATE

NON-PRESCRIPTION MEDICATION

(For medication such as Tylenol, Advil, Benadryl, etc.)

(Completed by Parent)

Name of medication: _____
Reason for Medication (illness): _____
Dosage _____ Time to be given: _____
Comments: _____

PRESCRIPTION MEDICATION

(Physician Signature Required)

Name of Medication: _____
Reason for Medication: _____
Specific time(s) and dose(s) to be given at school: _____
Method of Administration: _____ oral _____ IM injection _____ subq. Injection _____ inhalation _____ other
Comments: (side effects, and/or other instructions) _____

Printed Name of Physician

Signature of Physician

Date